Introduction

The purpose of this guide is to assist HIV prevention contractors in implementing effective HIV prevention programs that satisfy the Centers for Disease Control prevention guidelines and the Idaho STD/AIDS Program evaluation requirements. The guide contains information to support and implement quality programs and offers tools to develop and monitor evaluation objectives. You will find the guide is divided into five main sections: evaluation planning, completing the workplan, intervention guidelines and protocols, process monitoring, and behavioral monitoring.

Section I of the guide describes the purpose of different types of evaluation and was written specifically to assist contractors in developing an evaluation plan. The type of intervention described in the workplan will determine the level of evaluation required. For example, a health communication and public information intervention requires process monitoring. However, health education and risk reduction interventions aimed at behavioral change require both process and behavioral outcome monitoring. This section will also help you develop well-written goals, objectives, and intended outcomes for your interventions.

The Workplan template that accompanies this guide is designed to collect the program planning variables required by the Centers for Disease Control's (CDC) Program Evaluation and Monitoring System (PEMS). Section II defines the program plan variables contained in PEMS. PEMS is an internet-based software system that was developed by the CDC in order to systematically collect standardized data on a national level for the purpose of monitoring and evaluating prevention interventions.

Section III describes intervention guidelines and protocols for health education and risk reduction interventions, outreach, health communication, and public information and community level interventions. It includes a description of the necessary forms for process monitoring of all interventions and behavioral monitoring for health education and risk reduction interventions.

In Section IV you will find the reporting requirements for all intervention categories, including an outline of the process monitoring forms required to document activities were completed.

Section V contains the performance indicators and protocols for behavioral monitoring of health education and risk reduction group and individual level interventions, including prevention case management.

Section I: Developing an Evaluation Plan

Why Evaluate?

Accountability

- Evaluation provides a way of being accountable to a number of stakeholders including the funding source, program staff, clients, and community.
- Evaluation enhances the credibility of resource targeting and choice of interventions to serve your communities.

Program improvement

- Evaluation helps providers refine and improve existing interventions for maximum effectiveness.
- Evaluation increases motivation among staff and volunteers by offering a concrete way of tracking successes.

Knowledge development

- Evaluation provides systematic information about the status of HIV prevention efforts throughout a jurisdiction for ongoing planning.

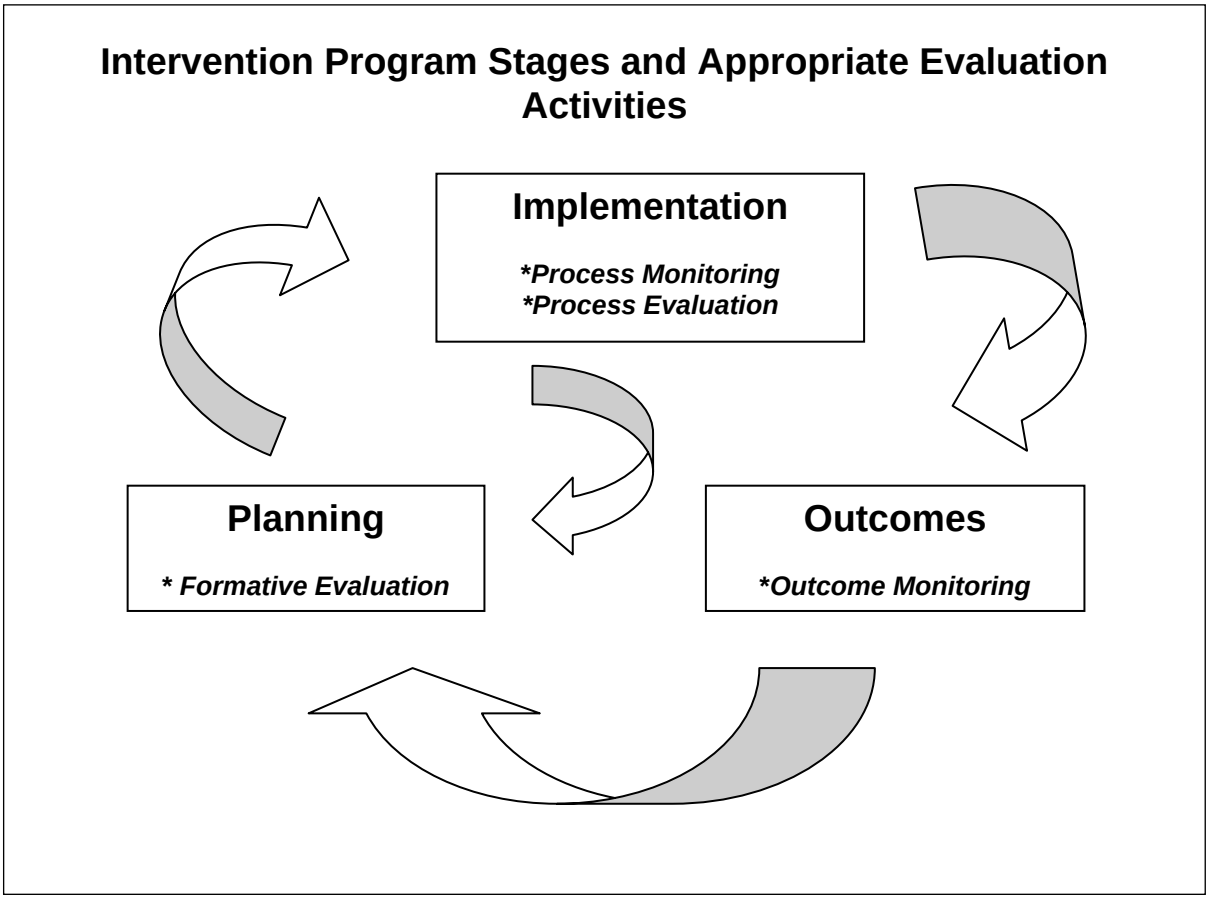
Social justice

- Evaluation ensures that HIV prevention resources are successfully reaching priority populations.

Relationship between Planning, Implementation, and Outcomes

Evaluation is an integral part of HIV prevention programs. Depending on what stage of the program cycle you are in, a particular type of evaluation can be utilized. This section describes the different types of evaluation, including how each one relates to a particular phase of the cycle – planning, implementation, and outcomes. The type of intervention that is planned will also determine the type of evaluation that is useful.

The diagram below illustrates the progression from planning an intervention to implementing the intervention to producing the desired results. Evaluation helps us to understand this process and the relationship between each step.



Types of Evaluation

Formative Evaluation:

Enables providers to design appropriate interventions.

Collects data describing the needs of the population and the factors that put them at risk. This information should be used by contractors in the planning stage of the intervention. Contractors can rely on the needs assessments conducted by the Idaho Care and Prevention Council, the Epidemiological Profile, and Counseling and Testing data. Contractors should also use data gathered locally to justify their interventions.

Answers questions such as:
Who is at risk?
What are the risky behaviors and why do they engage in those risky behaviors?
How should the intervention be designed or modified to address the target population needs?

When selecting, planning, and developing interventions, keep in mind that the CDC expects its grantees to deliver interventions which are based on a range of evidence which include:

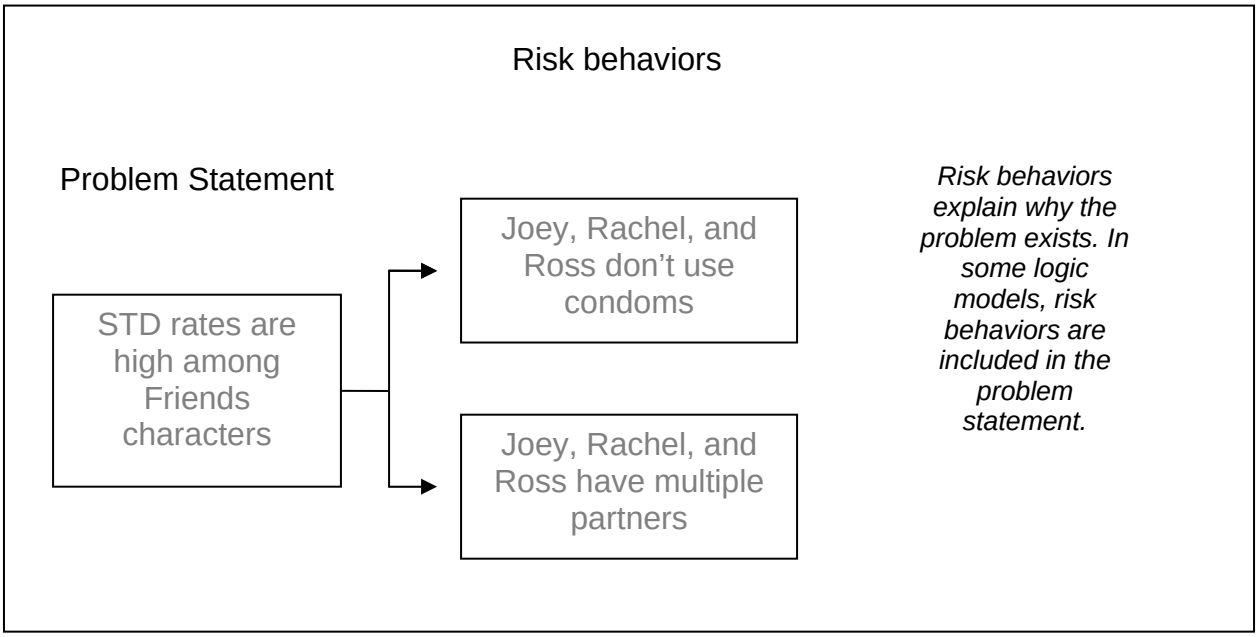
- **Evidenced-based interventions**, interventions that have been evaluated using behavioral or health outcomes which can be found in CDC's *Compendium of HIV Prevention Interventions with Evidence of Effectiveness* (1999). These interventions can either be implemented exactly as intended and within a similar context as the original intervention or adapted and tailored to a different target population if the core elements of the intervention are maintained.
- **Interventions with insufficient evidence of effectiveness,** but based on prior outcome monitoring data suggesting positive effects, but that cannot be rigorously proven; based on sound science and theory; based on a logic model that matches the science and theory to the intended outcomes of interest; and where the logic model matches with relevant behavioral-epi data from their community & target population.
- **Interventions with insufficient evidence of effectiveness,** and no prior outcome monitoring data available; based on sound science and theory; based on a logic model that matches the science and theory to the intended outcomes of interest; and where the logic model matches with relevant behavioral-epi data from their community & target population.

Process Monitoring: *Tells how much of an intervention (dosage) a client was exposed to or received.*	Collects data describing the characteristics of the population served, the services provided, and the resources used to deliver those services during the implementation stage of the intervention. The STD/AIDS Program requires contractors to complete process monitoring forms to collect this information based on CDC requirements. **Asks the questions**: What services were delivered? What population was served? What resources were used?
Process Evaluation: *Did we do what we said we were going to do?*	Collects more detailed data about how the intervention was delivered, differences between the intended population and the population served, and access to the intervention. Much of this data is collected through process monitoring forms and compared to program planning data. **Asks the questions:** Was the intervention implemented as planned? Did it reach the intended target? What barriers did clients experience in accessing the intervention?
Outcome Monitoring: *Did the client show changes in knowledge, attitudes, skills, and/or behavior?*	Collects data about client knowledge, attitudes, skills, and/or behaviors **before** and **after** the intervention. In their evaluation plans contractors are asked to identify the outcome objectives of health education and risk reduction interventions (HE/RR) and how they will be measured. Contractors will use approved measurement instruments tailored to the objectives of the intervention to measure objectives identified in their workplans. Behavioral outcome monitoring is required for HE/RR interventions in the Idaho STD/AIDS Program contract. Protocols and guidelines for HE/RR are found in Section III and protocols for Behavioral Outcome monitoring are found in Section IV. **Outcome monitoring asks the question:** Did the expected intended outcomes occur?

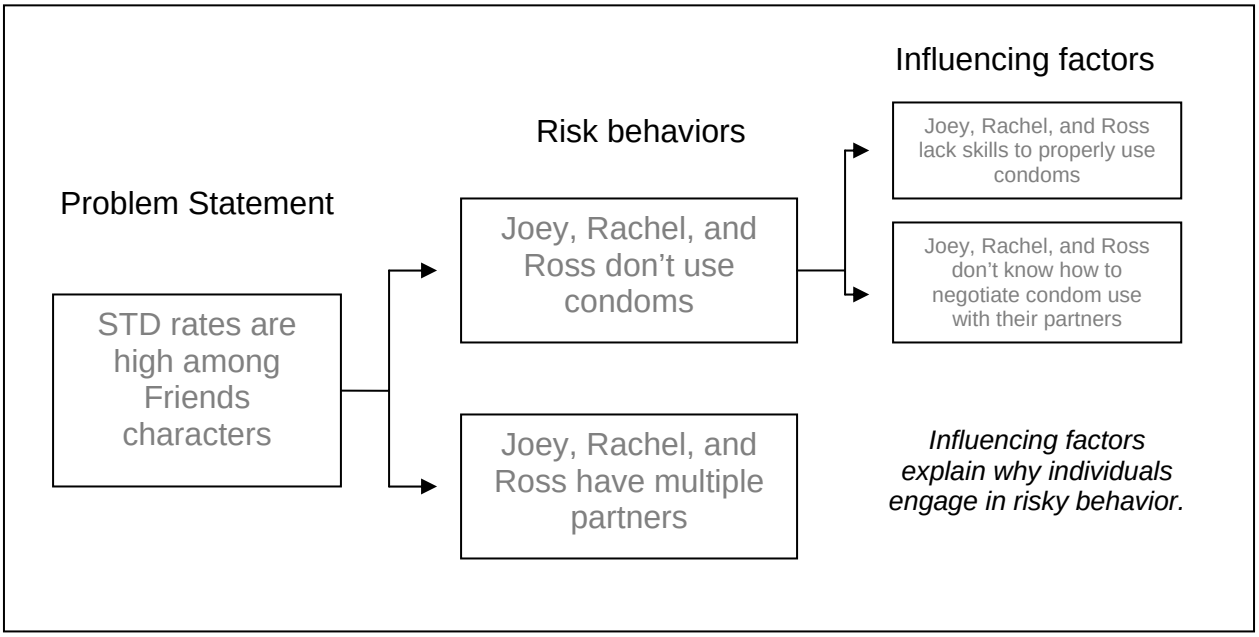
Describing Interventions with Logic Models

Before you begin measuring an intervention's success in achieving outcomes, you must be able to describe the intervention in detail and define what the expected outcomes are. A clearly described intervention is easier to evaluate and modify. A logic model is a tool for defining and describing an intervention. It describes the main elements of an intervention and how they work together to achieve expected outcomes. It illustrates a program's theory of change and how specified activities connect to the results or expected outcomes. Although logic models can be displayed in a number of different formats, one will be presented that works well for HIV prevention interventions.

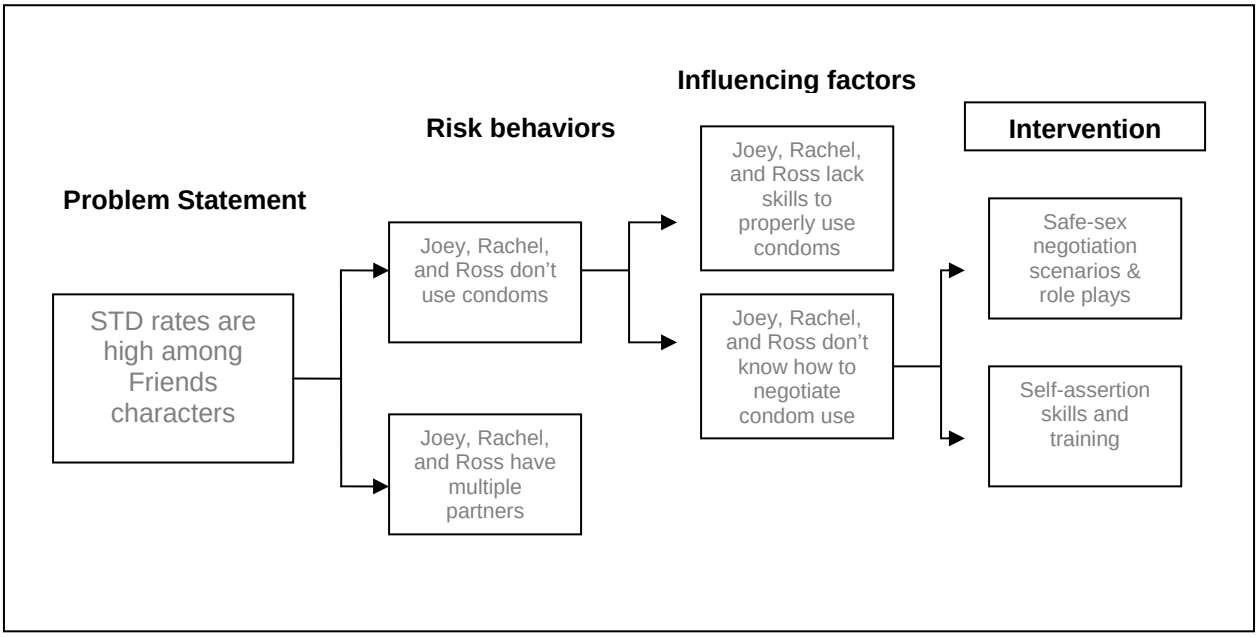
Logic models often start with a problem statement or condition. In our example case, our problem statement is "**STD rates are high among *Friends* characters**."



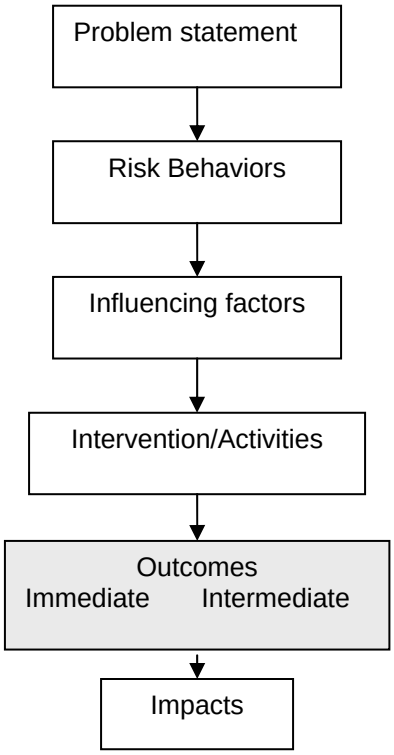
Reasons people engage in risky behavior are called *factors that influence behavior* (FIBs). A primary task of prevention planning and implementation is determining which interventions have the best chance of reducing risk behaviors. To reduce risky behavior among a given population, an intervention has to address the influencing factors. Attachment A contains a list of FIBs with brief definitions and examples.



In the next box the intervention is added to address the factors that influence behavior. The activities are the services that are provided to accomplish the intervention objectives. Activities can be delivered through outreach, materials distribution, counseling sessions, workshops, etc.



It is very important to include the expected outcomes in your logic model. What do you expect to happen to clients who participate in an intervention? Some of the outcomes will occur immediately after an intervention while others occur some time after the intervention is completed. **Outcome monitoring** will focus on collecting data to measure immediate outcomes, such as changes in a client's knowledge, attitudes, beliefs, and skills.



Immediate Outcomes: Immediate results of the intervention, such as changes in knowledge, attitudes, beliefs, and skills.

- Increased perception of HIV risk
- Increased condom use skills
- Increased condom use self-efficacy

Intermediate Outcomes: Intervention results that occur some time after the intervention is completed, such as changes in behaviors, skills, access, policies, and environmental conditions.

- Increased condom use

Impacts: Long-term results of one or more interventions over time, such as changes in HIV infection, morbidity, and mortality

- Decreased HIV rates

Changes in behavior are often the **intermediate outcomes** of an intervention. They describe the change that need to occur in the priority population's behavior that will lead to the goal of the intervention. These changes occur some time after the intervention.

Impacts are long-term results of one or more interventions over time, such as changes in HIV infection, morbidity, and mortality. Few agencies are able to conduct impact evaluation because of the time, costs, and personnel involved.

Logic Model Benefits

- They help monitor progress by providing a clear plan for tracking changes to the intervention so that successes can be replicated and mistakes avoided.
- They make explicit the expected outcomes of the intervention and help planners recognize when they are unrealistic.
- They show the relationship between the different elements of the intervention and help identify gaps in the plan.
- They reveal assumptions about how the intervention leads to outcomes and help contractors be more deliberate about what they are doing.
- They promote communication about the intervention among contractors, funding agencies, community members, and other stakeholders.

Suggestions/Tips for Creating and Using Logic Models

- Involve a group of individuals/stakeholders in the creation of the logic model.
- Remember that a logic model is a work in progress. Revisit it often and make changes to reflect the shifting needs of an agency or intervention.
- It is not necessary to put everything you do in an organization on a logic model. Be reasonable.
- A logic model is ideally developed during the process of planning an intervention, before implementation, but it's never too late to go back and put a logic model in place.
- Use a logic model to orient new staff involved in implementing the prevention intervention.

Developing a Goal Statement

In planning an effective intervention, well-written goals and objectives will help with the following:

- Quickly and easily communicate the intended results of the interventions to staff, stakeholders, and funding agencies.
- Provide clear directions for developing and monitoring the progress of intervention activities and evaluation.
- Describe how the prevention intervention will impact the behaviors and HIV risk and protective factors of the targeted population.
- Establish the criteria for evaluating the effectiveness of the intervention.

Writing the Goal Statement

A goal statement should be thought of a vision with a timeline. Goal statements broadly describe what the proposed intervention intends to accomplish and align with the *impacts* intended by the intervention. The goal to be achieved should be attainable. A good goal statement should include the following four components:

1. What change is going to occur
2. Who (what population) is going to change as a result of the intervention
3. Where (geographic location) the change is going to occur
4. When (by what date) the change will occur

Example: The STD/AIDS Program Positive Prevention Intervention will decrease the incidence of HIV by 10% among men who have sex with men in Region 10 of the state of Idaho over the next three years.

Writing Behavioral and Outcome Objectives

Writing clear objectives is an important part of both process and outcome monitoring. In this section, you will learn how to use the SMART method to write objectives that clearly describe how the intervention will be measured and evaluated. An intervention can have several objectives.

If behavioral change is necessary to achieve the intervention goal, then **behavioral objectives** are developed to communicate what changes in a specific behavior(s) will be achieved in order to accomplish the intervention goal. Behavioral interventions are aligned with the *intermediate outcomes* of an intervention.

A well written behavioral objective should contain the following five components:

1. What change in behavior is going to occur
2. Whose behavior is going to change
3. Where (geographic location) the change is going to occur
4. When the change will occur
5. How much change in a behavior will occur as a result of the intervention

In addition to including the five components, the objective should also be examined to see if it follows the guidelines of the SMART Method. This method guides the prevention worker through a series of questions that lead to the development of clearly defined objectives.

The SMART Method

S Specific. Objectives must be specific. This is equivalent to the "who" and "what" of the objective. The "who" refers to the target population and the "what" refers to the action. Be as specific as possible about the target population, and use only one action verb for each activity or action (behavior). Also, avoid verbs with vague meanings to describe intended outcomes (e.g., "understand" or "know"). Instead, use verbs that reflect action such as “list” or “demonstrate”. Remember, the greater the specificity, the greater the measurability.

M Measurable. It is impossible to determine whether or not the objectives have been met unless they can be measured. The focus here is on "how much" change is expected. The objective provides a reference point from which to measure change and one that is specific enough to be evaluated quantitatively or qualitatively.

A Achievable and Ambitious. The objective must be achievable and ambitious. This implies that it should be realistic given the program resources, yet challenging enough to accelerate program efforts. State- or local-level statistics provide context for what is reasonable and can help ensure that program objectives are achievable.

R Realistic. Objectives must be realistic. Objectives are most useful when they realistically address the scope of the problem, state reasonable programmatic steps that can be implemented within a specific timeframe, and directly focus on achieving a program goal.

T Time-bound. State a timeframe indicating when the objective will be measured or met.

Example Behavioral Objective:

Inadequate behavioral objective: “Decrease MSM risk behaviors”

Revised: “Between January 1 and December 31, 2006, 75% of MSMs in region 10 who participant in four one-hour group-level prevention sessions of the Positive Prevention Intervention will at follow-up report using a condom the last three times they engaged in anal intercourse.”

The SMART method can also be used to write **outcome objectives.** Outcome objectives describe how much change is expected in the risk and protective factors associated with the target behavior. Outcome objectives are aligned with immediate outcomes, as they describe the immediate results to be attained by the intervention such as changes in attitudes, knowledge, beliefs, and skills. The guidelines for writing outcome objectives are the same ones used for writing a behavioral objective. They are SMART: specific, measurable, achievable, realistic, and time-bound.

Components of an outcome objective include:

1. What risk or protective factor is going to change
2. Who is going to change
3. When should the outcome change be accomplished
4. How much change is expected

Example Outcome Objective:

Inadequate outcome objective: "participants will properly use a condom"

Revised: "At the end of the intervention, 100% of the targeted participants will demonstrate to the facilitator how to properly use and dispose of a condom."

Writing Process Objectives

Process objectives describe the specific intervention activities, the projected levels of effort needed to carry them out, the people responsible for carrying the activities out, and when the activities will be completed. Process objectives are also used to monitor and evaluate whether or not the intervention is delivered as intended.

Process objective components:

1. What activity is going to occur?
2. By when is the activity going to occur?
3. Where is the activity going to occur?
4. Who is going to conduct the activity?

Example process objective:

Inadequate process objective: "120 MSM will complete the intervention"

Revised: "By December 30, 2007, two Agency ABC peer educators and other staff will have implemented and evaluated 12 Positive Prevention cycles with 120 MSM participants in Region 10.

Estimating Appropriate Targets

When you write objectives you may have to do some estimating. Determining how many people might be reached, how much of a service might be delivered, or how much change can be expected to result from an intervention is not an easy task. If you do not reach your objectives, it might be because you did not estimate appropriate targets. In other words, your objectives might have been unrealistic.

Some suggestions for estimating appropriate targets:

- Past experience with the intervention or similar programs
- Past experience with the targeted population
- Process monitoring data and objectives
- Discussions with staff and other experts
- Published literature
- Agency capacity (staff, resources, etc.)

In reality, *you may not always meet your objectives*. Through trial and error, you may learn that you have set your targets too high and may need to adjust the numbers. *This is okay*. It is one way data are used (evaluation) to make programmatic decisions.

Selecting Outcome Objectives to Monitor

Conducting evaluation activities is costly in terms of funds, time, and other resources. Additionally, evaluation data are worthwhile only if they are used. For these reasons, it is important that our efforts and money to collect evaluation data are wisely spent.

When an intervention is ready to be evaluated, program staff has to select which objectives (whether process or outcome) it will monitor. The objectives should be relevant to the targeted population, the activities of the intervention, and changes in knowledge, attitudes, beliefs, and skills. Given available resources, however, it is usually not possible to monitor every objective. In deciding which objectives to measure, you should keep in mind how easily the information can be collected (feasibility) and how important the information is to know (usefulness).

A plan for outcome monitoring includes the following information:

- The intended behavioral and outcome objectives of the intervention
- A statement of how the objectives will be measured
- Description of how and when the measurement tools will be administered
- Copies of the measurement tools used for behavioral and outcome monitoring
- Identifies which area of the tool will be used to measure the intended outcomes of the intervention

Section II: Completing the Workplan

A word about Program Models:

CDC has stressed the use of interventions with evidence of effectiveness, including models in the Disseminating Effective Behavioral Interventions initiative also known as DEBI. Although STD/AIDS Program contractors are not limited to using DEBI models, you should know that the Program Evaluation and Monitoring System (PEMS) has been structured with these interventions in mind.

The PEMS data collection system for intervention planning is built upon program models. A program model is comprised of various interventions with specific risk reduction activities. Typically, a program model targets a high-risk population with interventions that are used for recruitment (outreach) into higher level services such as Health Education and Risk Reduction interventions or counseling and testing services. Thus you may utilize more than one program model within your agency if your agency targets more than one high-risk population.

The CDC has developed procedural guidance for the use of DEBI program models and for tailoring and adapting these models to meet the needs of local jurisdictions. Although the procedural guidance was developed for directly funded (receives funding directly from CDC) community based organizations (CBOs) it contains information useful for indirectly funded (receives funding through contracts with IDHW) grantees. The procedural guidance may be found on the CDC web site at: http://www.cdc.gov/hiv/partners/AHP/CBOProcedures_15Dec03_FinalDraft.pdf

The Workplan Templates

HIV prevention intervention contracts include workplans that give detail on how interventions are to be implemented. The Workplan templates used by the STD/AIDS Program are modeled upon the program planning variables collected by the Program Evaluation and Monitoring System (PEMS). There are five different workplan worksheets; one to collect program model information and four to collect intervention plan information. The five worksheets below are found in Attachment B:

- ✓ Workplan/Program Information
- ✓ Workplan/Health Education and Risk Reduction Interventions
- ✓ Workplan/Non-HE/RR Outreach Interventions
- ✓ Workplan/Health Communication and Public Information Interventions
- ✓ Workplan/Community Level Interventions

The tables below define and give guidance on completing the variables on each of the workplan templates.

Workplan Section: Program Information Complete one for each Program Model	
Variables	**Definition**
Agency Name	The official legal name of the agency or organization. *Examples: Idaho Department of Health and Welfare* *District 10 Health Department*
Program Name	The name used by an agency to identify a specific program that is designed to provide HIV Prevention services to clients. The Program Name links the Agency Name with the Program Model and distinguishes it from other programs provided within the same agency. If an agency only has one Program, then the Program Name could be the same as the Agency Name. *Example: STD/AIDS Program* *Region 10 HIV Prevention Project*
Program Model Name	A name used by an agency that represents the specific set of components or activities present in a Program. This variable allows the provider to develop and use a unique name for a Program Model that distinguishes it from other Program Models within the same agency. A Program can have one or multiple program models. *Example: Prevention Case Management* *Positive Prevention Model*
Community Planning Year	Indicate the Community Planning Year in which this program was initiated. (current Community Planning Year)
Basis for Program Model	**Study Replication Model -** A program that has evidence of effectiveness through research studies that have shown positive behavioral and/or health outcomes. Indicate the program model that was replicated in designing this prevention program and structuring the prevention activities. If prevention program is not based on a replicated model, please enter None. Program models must retain the core elements of the Study Replication Models. Information about DEBI interventions can be found at: http://www.effectiveinterventions.org/index.cfm *See Attachment C for a list of replication models.* **Procedural Guidance –** If a Study Replication Model cannot be considered the basis for a program model, then select from the list of CDC procedural guidelines that were used in designing the prevention intervention activities. If the program model is not based on procedural guidance, please enter None. ***Procedural Guidance* is the appropriate choice for contractors conducting prevention case management (PCM). Counseling and testing and partner counseling and prevention services (PCRS) are also procedural guidance interventions, however, only PCM is covered in this guidance.** *See Attachment C for a procedural guidance list* **Other Basis for Program Model –** This is the appropriate category for program models that are based on a health behavior model or theory. “Home

Workplan Section: Program Information Complete one for each Program Model	
Variables	**Definition**
	grown" interventions or interventions loosely adapted from study replication models fit this category. For adapted models to fit the study replication model category they must maintain the core elements of the original model. *When completing this category, indicate the scientific, theoretical or operational basis for the program and how it works to achieve the objectives of the intervention.* If applicable, specify the published article or study upon which this program is modeled, or briefly describe the source of the model for the program. A logic model can be used to describe the intervention.
Target Population	The target population(s) is composed of the primary individuals that this intervention is designed to affect. Target populations are generated from the priority populations described in Idaho's Community Planning (CP) Comprehensive HIV Prevention Plan. If the target population of this intervention is not one of the CP priority populations, choose "Other" and specify. Idaho's priority populations are as follows: 1. HIV + persons 2. Men who have sex with men (MSM) 3. High risk heterosexuals (HRH) 4. Injection drug users (IDU) 5. Youth

The following Workplan Sections gather: Intervention Information Complete one for each intervention under a Program Model

Workplan/Health Education and Risk Reduction Intervention Plan Client Level Reporting	
Variables	**Definition**
Agency, Program Name, Program Model Name	Same as above under Program Information worksheet.
Intervention Name	The unique name of the intervention. Each intervention within a Program Model must have a unique name that will link it to the client-service level data so it is distinguishable between multiple interventions under the same program model. Remember each program model targets a specific population. For Example*: If Region 10 Health Department (Agency), used Positive Prevention (Program Model) that had outreach and two group-level activities, the outreach and two group-level activities must all have distinguishable intervention names and their own workplan. In this case the Program Model would have three different interventions described by three separate workplan worksheets.*
Intervention Type	**Individual-Level Intervention –** Health education and risk-reduction counseling provided to one individual at a time. ILI assists clients in making plans for individual behavior change and ongoing appraisals of their own

Workplan Section: Program Information Complete one for each Program Model	
Variables	**Definition**
	behavior and includes skills building activities. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV, and they help clients make plans to obtain these services. **Group-Level Intervention –** Health education and risk-reduction counseling that shifts the delivery of service from the individual to groups of varying sizes. GLI uses peer and non-peer models involving a wide range of skills, information, education, and support. **Prevention Case Management:** Client-centered HIV prevention activity with the fundamental goal of promoting the adoption and maintenance of HIV risk-reduction behaviors by Ryan White Title II Program clients with multiple, complex problems and risk-reduction needs; a hybrid of HIV risk-reduction counseling and traditional case management that provides intensive, ongoing, and individualized prevention counseling, support, and service brokerage. **One-to-One Outreach (Encounter):** Intensive client level outreach with direct one-to-one client contact for the purpose of providing risk reduction or skills building HIV prevention services and may include a referral to other services. *See Section III for more information on intervention types and protocols*
HIV + Intervention	An intervention that targets Persons Living with HIV/AIDS (PLWH) or PLWH and their sex and/or drug using partners.
Planned Number of Cycles	The number of times a unique intervention is intended to be delivered in its entirety over the Program Model period. A **cycle** is a complete delivery of an intervention to its intended audience. **Example:** Your group level intervention is delivered over 6 sessions and you plan to run the intervention 4 times throughout the year. This intervention has 4 cycles. Your individual level intervention is delivered in 5 sessions. You intend to reach 15 clients throughout the year. Your ILI plans for 15 cycles each have 5 sessions.
Number of Sessions	The total number of sessions planned for an intervention. An intervention **session** consists of one or more activities delivered to clients on a given date. For PCM, the number of sessions may be unknown. Just enter “unknown.”
Duration of Session	The duration of the session in minutes.
Duration of Intervention Cycle	The measure of time used to describe the duration of the intervention cycle. Indicate the specific measure o time in “days” or “months” used to describe the duration of the intervention cycle.

Workplan Section: Program Information Complete one for each Program Model	
Variables	**Definition**
	Examples: If eight sessions are delivered two times a week over consecutive weeks, the duration would be **1 month**. If eight sessions are delivered 4 times a week over two consecutive weeks, the duration would be **14 days**.
Estimated Number of Clients	For the primary target population identified under the program model, indicate the annual number of clients intended to be reached by the intervention. If a secondary population was identified, indicate how many clients are estimated for this population as well. Adding the primary and secondary targets will give the total number of clients to be reached by the intervention.
Level of Data Collection	**Individual:** Client-level data will be collected for prevention case management interventions (PCM) and most individual-level HE/RR. It may be appropriate for some group-level HE/RR and outreach interventions where appropriate.
Risk Behavior Data-Collection	Indicate yes or no whether or not this particular intervention will include the collection of individual client HIV risk behavior information. Reporting of risk behavior data is required by CDC for client's enrolled in Prevention Case Management. **The STD/AIDS Program requires behavioral monitoring for PCM, HE/RR group and individual level interventions. See Section V for Behavioral Monitoring Protocols.**
Specified Recall Period *(This variable applies to interventions in which client level data is gathered. It would not apply to outreach interventions where aggregate data are gathered.)*	Indicate the recall period used for the collection of detailed behavioral data. The period of time prior to data collection within which a client has performed certain risk behaviors. **Recall Period at Intake:** PEMS: At intake there is an option to choose two recall periods: 90 days AND 15 or 30 days. STD/AIDS Program: Behavioral monitoring forms have a 90 day recall period. **Recall Period after Intake:** PEMS: After intake, the recall period for behavioral data is either 15 or 30 days. The recall period used at intake becomes the standard recall period for subsequent data collection. Selection of a 15 or 30 day recall period must make logical sense in terms of the duration of the intervention cycle. STD/AIDS Program: Follow behavioral monitoring protocols for your intervention.

Workplan Section: Program Information Complete one for each Program Model	
Variables	**Definition**
	Examples for recall periods: If the intervention duration is over 60 days, it makes sense that the recall period after intake would be 30 days. A question using a 30-day recall period is: *How many times have you had unprotected sex in the past 30 days?* For interventions where the first session and last session are separated by less than 30 days, the recall period choice would be 15 days.
Unit of Delivery	The category or grouping of intended clients per session for a unique intervention. Individual (1 person), couple (2 people), small group (3-12 people), large group (13-30 people), & community (>30)
Delivery Method	**In person**= intervention is delivered by an individual or a group of individuals. Includes counseling, face to face discussions, facilitating group activities, lectures, presentations, etc. **Internet**= Delivered through email, chat rooms, or websites. **Printed materials**= Includes pamphlets, direct mailing, magazines, newspapers, posters, billboards, etc. Choose the specific sub categories for printed material. **Radio**= Delivered through broadcast station using public service announcements, commercial air time, ect. **Telephone**= Delivered by telephone. **Television**= Delivered through broadcast station using public service announcements, commercial air time, ect. **Video**= Delivered by viewing recorded message. **Other**= Please specify
Language of Intervention Delivery	The primary language through which the intervention is delivered
Activity	The specific components that are to be performed during the implementation of a particular intervention. **This variable is required for each session.** A session can have several activities. *See Attachment D for PEMS activity list.*
Behavioral Objectives of Intervention	**Must be completed for ILI, GLI, and PCM interventions**. *See Section I: Developing an Evaluation Plan: Writing behavioral objectives*
Outcome Objective(s)	**Must be completed for ILI, GLI, and PCM interventions**. *See Section I: Developing an Evaluation Plan: Writing outcome objectives.*
Site Information	This is the point of service delivery for the intervention. It can be a facility or non-facility based (e.g. park, street corner) setting.

Workplan Section: Program Information Complete one for each Program Model	
Variables	**Definition**
Site Name	The name of the agency's HIV prevention site.
Site Type	*See Attachment E for a complete list of PEMS site types.*
Site Contact Information	Please supply site address, county, phone, fax, email, and site contact's name and title if it is different from your agency location.

Workplan/Non-HE/RR Outreach	
Agency **Program Name** **Program Model Name** **Intervention Name**	Follow same directions above under Program Information worksheet and Health Education and Risk Reduction worksheet.
Outreach Type	Two choices are available: Materials Distribution and Recruitment. Both types can be chosen. Outreach described in this workplan does not involve individualized risk reduction. See Section III: Non-HE/RR Interventions for explanation of outreach types.
Outreach Method	Chose all that apply. See Section III: Non-HE/RR Interventions for explanation of outreach methods.
HIV+ Intervention	An intervention that targets Persons Living with HIV/AIDS (PLWH) or PLWH and their sex and/or drug using partners.
Planned Number of Cycles	The number of times a unique intervention is intended to be delivered in its entirety over the Program Model period. A **cycle** is a complete delivery of an intervention to its intended audience. The planned number of times the outreach activity will occur throughout the project year. The outreach method used will help determine how many times the outreach activity will occur. For example: If outreach is to a fixed site and the site is visited two days each month, the number of cycles would be **24**. If outreach is active street and the outreach worker visits pre-determined street corners 1 afternoon each week, the number of cycles would be approx **48**. If outreach is drop-off site and materials are dropped of 1 time each month, the number of cycles would be **12.**
Number of Sessions:	Most non-HE/RR outreach will not have multiple sessions (check unknown) unless the plan is to meet with a client more than once.
Duration of Sessions:	Indicate length of the session if known.

Workplan/Non-HE/RR Outreach	
Duration of Intervention Cycle:	Most cycles will be one day unless intervention cycle is an event that occurs over multiple days (i.e. a mobile van set up at a fixed site over a weekend)
Estimated number of clients to be reached this year for target population (s) indicated under the program model:	For the primary target population identified under the program model, indicate the **number** of clients intended to be reached by the intervention. If a secondary population was identified, indicate how many clients are estimated for this population as well.
Unit of Delivery	The category or grouping of intended clients per session for a unique intervention. Individual (1 person), couple (2 people), small group (3-12 people), large group (13-30 people), & community (>30)
Delivery Method	**In person**= intervention is delivered by an individual or a group of individuals. Includes counseling, face to face discussions, facilitating group activities, lectures, presentations, etc. **Internet**= Delivered through email, chat rooms, or websites. **Printed materials**= Includes pamphlets, direct mailing, magazines, newspapers, posters, billboards, etc. Choose the specific sub categories for printed material. **Radio**= Delivered through broadcast station using public service announcements, commercial air time, ect. **Telephone**= Delivered by telephone. **Television**= Delivered through broadcast station using public service announcements, commercial air time, ect. **Video**= Delivered by viewing recorded message. **Other**= Please specify
Language of Intervention Delivery	The primary language through which the intervention is delivered
Activity	The specific components that are to be performed during the implementation of a particular intervention. **This variable is required for each session.** A session can have several activities. *See Attachment D for PEMS activity list.*
Process Objective(s)	Describes the specific intervention activities, the projected levels of effort needed to carry them out, the people responsible for carrying the activities out, and when the activities will be completed. *See Section I: Developing an Evaluation Plan: Writing Process objectives.*
Site Information	This is the point of service delivery for the intervention. It can be a facility or non-facility based (e.g. park, street corner) setting.

Workplan/Non-HE/RR Outreach	
Site Name	The name of the agency's HIV prevention site.
Site Type	*See Attachment E for a complete list of PEMS site types*.
Site Contact Information	Please supply if it is different from your agency location. Please supply site's address, County, Phone, Fax, Email, and Site Contac's Name & Title.

Workplan/Health Communication/Public Information	
Agency, Program Name, Program Model Name, Intervention Name	Follow same directions above under Program Information worksheet and Health Education and Risk Reduction worksheet.
HIV+ Intervention	An intervention that targets Persons Living with HIV/AIDS (PLWH) or PLWH and their sex and/or drug using partners.
Planned Number of Cycles	The number of times a unique intervention is intended to be delivered in its entirety over the Program Model period. A **cycle** is a complete delivery of an intervention to its intended audience. The planned number of times the health communication/Public Information activity will occur throughout the project year. For example: If an email message containing prevention information is sent 2 times per month, the number of cycles would be **24**. If a prevention message is delivered over the radio 50 times over three months, the number of cycles would be approx 50. If a presentation is given 1 time each month, the number of cycles would be **12.**
Duration of Intervention Cycle:	Most cycles will be one day unless intervention activities occur over multiple days.
Estimated number of clients to be reached this year for target population (s) indicated under the program model:	For the primary target population identified under the program model, indicate the **number** of clients intended to be reached by the intervention. If a secondary population was identified, indicate how many clients are estimated for this population as well.
Unit of Delivery	The category or grouping of intended clients per session for a unique intervention. Individual (1 person), couple (2 people), small group (3-12 people), large group (13-30 people), & community (>30)
Delivery Method	**In person**= intervention is delivered by an individual or a group of individuals. Includes counseling, face to face discussions, facilitating group activities, lectures, presentations, etc. **Internet**= Delivered through email, chat rooms, or websites. **Printed materials**= Includes pamphlets, direct mailing, magazines, newspapers, posters, billboards, etc. Choose the specific sub categories for printed material. **Radio**= Delivered through broadcast station using public service announcements, commercial air time, ect. **Telephone**= Delivered by telephone.

Workplan/Health Communication/Public Information	
	Television= Delivered through broadcast station using public service announcements, commercial air time, ect. **Video**= Delivered by viewing recorded message. **Other**= Please specify
Language of Intervention Delivery	The primary language through which the intervention is delivered
Activity	The specific components that are to be performed during the implementation of a particular intervention. **This variable is required for each session.** A session can have several activities. *See Attachment D for PEMS activity list.*
Process Objective(s)	Describes the specific intervention activities, the projected levels of effort needed to carry them out, the people responsible for carrying the activities out, and when the activities will be completed. *See Section I: Developing an Evaluation Plan: Writing Process objectives.*
Site Information	This is the point of service delivery for the intervention. It can be a facility or non-facility based (e.g. park, street corner) setting.
Site Name	The name of the agency's HIV prevention site.
Site Type	*See Attachment E for a complete list of PEMS site types.*.
Site Contact Information	Please supply if it is different from your agency location. Please supply site's address, County, Phone, Fax, Email, and Site Contac's Name & Title.

Workplan/Community Level Intervention	
Other Intervention/ Community Level Intervention:	Those interventions funded with CDC funds that cannot be described by the definitions provided for the other six types of interventions. This category includes community-level interventions (CLI). CLIs seek to improve the risk conditions and behaviors in a community through a focus on the community as a whole, rather than by intervening with individuals or small groups. This is often done by attempting to alter social norms, policies, or characteristics of the environment.
Program Model Name:	A name used by an agency that represents the specific set of components or activities present in a Program. This variable allows the provider to develop and use a unique name for a Program Model that distinguishes it from other Program Models within the same agency. A Program can have one or multiple program models.
Intervention Name:	The unique name of the intervention. Each intervention within a Program Model must have a unique name that will link it to the client-service level data so it is distinguishable between multiple interventions under the same program model. Remember each program model targets a specific

Workplan/Community Level Intervention	
	population.
Activities Under Other:	**Community-Wide Events/Awareness**– includes outreach to general public **Community Mobilization**- Community mobilization is the process by which community citizens take an active role in defining, prioritizing, and addressing issues in their community. This process focuses on identifying and activating the skills and resources of residents and organizations while developing linkages and relationships within and beyond the community for the purpose of expanding the current scope and effectiveness of HIV/STD prevention. **Policy Intervention-**intervention that changes social policy in order to lessen risky conditions and behaviors in a community. Be aware, that CDC funding cannot be used to lobby federal or local legislative bodies. Nor can CDC funds be used in efforts to support or defeat pending legislation. **Social Marketing Campaigns-**used as a strategy in the planning process, design, and dissemination of HIV prevention programs. Its major focus is on the receiver of the intervention and how to maximize the perceived benefits of the intervention. **Structural Interventions-** Interventions designed to remove barriers and incorporate facilitators of an individual's HIV prevention behaviors. These barriers or facilitators include physical, social, cultural, organizational, community, economic, legal, or policy circumstances or actions that directly or indirectly affect an individual's ability to avoid exposure to HIV.

Section III – Intervention Guidelines and Protocols

Health Education and Risk Reduction Standards and Protocols

A mission of the STD/AIDS Program is to support and promote quality HIV prevention programs for Idahoans at risk. In this effort, we have developed minimum standards and protocols for the delivery of Health Education and Risk Reduction interventions. These interventions provide knowledge of HIV and its transmission and perhaps more importantly support individuals in reducing their risk by teaching skills to protect themselves from infection. In addition to developing a standard of quality, we hope that these protocols will offer guidance in the delivery and evaluation of interventions. Observance of these standards and protocols will be evaluated during program planning, through process monitoring, and at site visits.

HIV Educator Standards (Many of the educational standards are highly recommended but not required unless specified.)

Education and skills:

- HIV educators should have appropriate formal education, preferably a bachelor's or master's degree in a health sciences related field. Work experience in the field of HIV/AIDS/STD is an added advantage. In lieu of a Bachelor's degree, education can be substituted with 2 years of community based organization work experience in the field of HIV/AIDS/STD.
- Demonstrated ability to meet the key characteristics required of the planned intervention. Educators implementing a DEBI model should receive training specific to the delivery of the model by a qualified trainer.
- HIV educators should receive a minimum of 4 hours of training on a yearly basis in one or more of the following areas:
  - ✓ HIV/AIDS
  - ✓ sexually transmitted diseases
  - ✓ counseling and testing procedures
  - ✓ legal issues surrounding HIV/STDS
  - ✓ tuberculosis, viral hepatitis, human sexuality, reproductive health and birth control
  - ✓ substance abuse
  - ✓ mental health
  - ✓ Racism, cultural sensitivity, and homophobia
  - ✓ behavioral theory, program evaluation or other training as approved by STD/AIDS Program staff

Employers shall document training(s) in employment records and report trainings attended to STD/AIDS Program at site visits.

In addition:

- HIV educators should understand the basics of behavioral science theory and be able to integrate these into planned prevention activities.
- HIV educators should have experience in facilitation and client centered counseling.
- HIV educators should be able to conduct a sexual and drug use history and risk assessment and be able to assist clients in developing a risk reduction plan.

- HIV educators should be able to refer participants to clinical care, drug treatment and other community services.
- HIV educators should be able to assess needs for health education programs and plan effective health education programs.
- HIV educators should be able to implement health education programs and evaluate the effectiveness of health education programs.

Prevention Case Management

Client-centered HIV prevention activity with the fundamental goal of promoting the adoption and maintenance of HIV risk-reduction behaviors by Ryan White Title II Program clients with multiple, complex problems and risk-reduction needs; a hybrid of HIV risk-reduction counseling and traditional case management that provides intensive, ongoing, and individualized prevention counseling, support, and service brokerage.

Protocols and Standards for PCM

- Clients enrolled in PCM will have a completed *Ryan White Title II Services* form (intake form) and documented eligibility on *PCM Screening* form submitted to Ryan White Title II Health Program Specialist. HIV Prevention Program Specialist will verify that these documents have been submitted to the Ryan White Title II Health Program Specialist.
- Intervention must have at the very least 2 sessions spread over time. The number of sessions needed is determined by the provider and the client.
- Conduct a thorough client-centered Risk Assessment with client.
- Develop a written *Risk Reduction Plan* with the client's participation, which specifically defines HIV risk-reduction behavioral objectives and strategies. The plan includes a way to measure the goal(s) and a time frame upon which to complete the goal(s). The client should sign-off on the mutually negotiated Risk Reduction Plan to ensure their participation and commitment.
- Client files, including a copy of the individual Risk Reduction Plan, must be maintained in a locked file cabinet to ensure confidentiality.
- Client PCM records must contain a copy of the voluntary informed consent document and a *Risk Reduction Plan* showing the client's signature.
- Complete the *Individual Level Program Participant Form*, *HIV Individual Level Prevention Intervention: Session Details and Client Behavior Details* forms at the first PCM session. These forms are submitted to the STD/AIDS Program with sessions billed to PCM under the HIV Prevention Contract.
- Complete the *HIV Individual Level Prevention Intervention: Session Details* form after each successive session to document date, session number, location and activities that took place with client.
- Document client progress on *Risk Reduction Plan* goal(s) after each meeting (a notation can be made on the *HIV Individual Level Prevention Intervention: Session Details* form regarding client progress). The client should initial and date goals that are achieved on the *Risk Reduction Plan.*
- Administer *Client Behavior Details* at the last session and intermittently as appropriate. For example, if the time frame to achieve goals is several months and the client was engaging in very risky behavior at the first session, it would be appropriate to administer the Client Behavior Details periodically to help gage client progress.

- When client and provider determine that PCM is complete, on the *HIV Individual Level Prevention Intervention: Session Details* in the Current Session # field indicate the session number and write in “last session”. A notation should be made in the *Risk Reduction Plan* field to indicate the status of the client’s risk reduction goals.

Individual-Level Intervention (ILI)

Health education and risk-reduction counseling provided to one individual at a time. ILI assists clients in making plans for individual behavior change and ongoing appraisals of their own behavior and includes skills building activities. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV, and they help clients make plans to obtain these services.

Excludes: Outreach, prevention case management, and counseling & testing each of which has its own category.

Protocols and Standards for ILI

- The intervention should be client driven and should target a specific risk behavior or behaviors.
- Staff conducting individual level interventions should be trained in client centered counseling.
- Client rights and responsibilities should be established prior to the start of the intervention (e.g. confidentiality)
- The intervention should not provide messages that are judgmental, moralistic, or that attempt to instill fear.
- Unless an Individual Level Intervention is intended to be delivered only once because it is a component of a program where client is receiving other prevention services (e.g., Voices/Voces, Street Smart), the intervention should have at the very least 2 sessions spread over time. The intervention may be structured or the number of sessions may be determined at the time a *Risk Reduction Plan* is developed with the client.
- The intervention must include a risk assessment and skills building component.
- The provider and client should develop a *Risk Reduction Plan* that specifies at least one HIV Education and Risk Reduction goal, includes a way to measure the goal(s) and a time frame upon which to complete the goal(s) for the desired outcome.
- The *Risk Reduction Plan* developed should be appropriate for the culture and language of the client; with sensitivity to norms, attitudes, and beliefs relevant to the targeted population.
- Client files that include client level data, including an individual *Risk Reduction Plan*, must be maintained in a locked file cabinet to ensure confidentiality.
- Complete the *Individual Level Program Participant Form*, *HIV Individual Level Prevention Intervention: Session Details and Client Behavior Details* forms at the first individual level intervention session.
- Complete the *HIV Individual Level Prevention Intervention: Session Details* form after each successive session to document date, session number, location and activities that took place with client.
- Document client progress on *Risk Reduction Plan* goal(s) after each meeting (a notation can be made on the *HIV Individual Level Prevention Intervention: Session Details* form). The client should initial and date goals that are achieved on the *Risk Reduction Plan.*

Group-Level Intervention

Health education and risk-reduction counseling that shifts the delivery of service from the individual to groups of varying sizes. GLI uses peer and non-peer models involving a wide range of skills, information, education, and support. ***Excludes: Any group education that lacks a skills component (e.g., information only education such as "one-shot" presentations). These types of interventions should be included in the HC/PI category.***

Protocols and Standards for Group-Level Intervention

- There should be a commonality or link between participants that identifies them as members of the group.
- The provider should obtain or develop a curriculum that defines the goals and objectives of the program including core elements and/or key characteristics of the intervention.
- The curriculum selected should be appropriate for the culture and language of participants.
- The intervention will have established completion criteria that indicate the required sessions needed for the client to get the full effect of the intervention (core elements).
- The intervention will be delivered consistently with HIV education and risk reduction goals and objectives that are measurable for the purpose of evaluation.
- The intervention should be provided in a nonjudgmental manner.
- Ground rules addressing attendance, participation, honesty, trust and confidentiality should be established with participants at the start of the intervention.
- To the extent possible, the physical environment should be accessible and acceptable to the population.
- The provider should be trained in group facilitation skills.
- Upon enrollment in the intervention an *HIV Prevention Program Participant Form* is completed. The *Pre Intervention HIV Risk Behavior Questionnaire* is administered at the first session to gather data used to evaluate behavior change. The provider may also administer outcome monitoring tools specific to intervention objectives not measured by the STD/AIDS Program Behavioral Monitoring Tools.
- Session attendance is documented on the *HIV Prevention Participant Sign-In Form* and an *HE/RR-Group-Level Intervention-Session Report Form* is used to describe each session.
- Administer *End of Intervention HIV Risk Behavior Questionnaire* at last session
- At least one month after intervention send 30-Day *Follow-Up HIV Risk Behavior Questionnaire* to client with a Bureau of Clinical & Preventive Services return envelope.

Client Level Outreach

Includes ongoing encounters in which outreach workers spend extended periods of time with clients, assess risks, make plans with clients for behavior change, and provide referrals. The outreach worker and client meet on multiple occasions. Outreach workers may also facilitate client's entrance into services and should verify follow-through on referrals when possible. Both process and outcome evaluation should be used in assessing this type of outreach. **Client level outreach is not the same as alternate site HIV testing. However, client level outreach may facilitate a client to receive HIV testing.**

Protocols and Standards for Client Level Outreach (one-to-one)

- Agencies with staff conducting client level outreach should have safety protocols in place and all outreach staff should receive safety training before conducting outreach activities.

  "For CDC funded (directly or indirectly) agencies using youth (either paid or volunteer) in program outreach activities, it is very important that said organizations use caution and judgment in the venues/situations where youth workers are placed. Agencies should give careful consideration to the "age appropriateness" of the activity or venue. Additionally, agencies should comply with all relevant laws and regulations regarding entrance into adult establishments/environments. Laws and curfews should be clearly outlined in required safety protocols developed and implemented by agencies directly and indirectly funded by CDC."

- Staff conducting client level outreach should be skilled in counseling, cultural competency, substance use/abuse, and have the ability to develop rapport with the population being targeted.
- The intervention should not provide messages that are judgmental, moralistic, or that attempt to instill fear.
- The outreach worker should attempt to establish a trusting relationship with the client before engaging in personal risk reduction. Once the client is engaged and agrees to work on personal risk reduction activities a risk assessment should be conducted and the intervention officially becomes client level outreach.
- Complete the *HIV Program Participant Form* and administer the accompanying *HIV Risk Behavior Questionnaire* to determine behaviors in the last 90 days. The form can be completed after client contact based on information gathered from the risk assessment.
- The provider and client should develop a *Prevention Plan* that specifies HIV Education and Risk Reduction goals, includes a way to measure the goals and a time frame upon which to complete the goals for the desired outcome. If necessary, this can be done verbally and documented by the outreach worker after the encounter.
- The Prevention Plan developed should be appropriate for the culture and language of the client; with sensitivity to norms, attitudes, and beliefs relevant to the targeted population.
- Client files that include client level data, including an individual *Prevention Plan*, must be maintained in a locked file cabinet to ensure confidentiality.
- Complete the *HE/RR-Individual-Level-Session Report Form* after each client contact to document date, session number, location and activities that took place with client.
- Document client progress on *Prevention Plan* after each meeting (a brief note can be made in the comments section on the Session Report Form).
- Periodically (every 30 to 60 days), administer the *HIV Risk Behavior Questionnaire* on the *HIV Program Participant Form* to assess and report client progress on risk behaviors.

Community Level Intervention – A distinct class of programs characterized by their scope of objectives. A community level intervention is designed to reach a defined community (i.e. an identified risk population within a geographic area) with the intention of altering social norms in that community as a way to influence at-risk behavior. A community level intervention may include aspects of other categories, but the combination must be aimed explicitly at community norms in order to be classified as a community-level intervention. Community level interventions seek to improve the risk conditions and behaviors in a community through a focus on the community as a whole, rather than by intervening with individuals or small groups. This is often done by attempting to alter social norms, policies, or characteristics of the environment.

Non HE/RR Interventions

Basic Street and Community Outreach

This type of outreach is primarily conducted for the purpose of referral or recruitment into other services. Outreach workers engage contacts in brief conversations, providing information, literature, condoms, referrals, ect. Basic street/community outreach is important for establishing rapport within a community and building trust with individuals. It can be used as a method for bringing clients into other services such as intensive street outreach, counseling and testing, prevention case management, and health education and risk reduction interventions. *(See table below for further definition of outreach types)*

- Report non-HE/RR outreach activities on the *Non HE/RR Intervention Report Form*.

Outreach	Involves promoting HIV prevention services through approaching people who may be in need, in parks, homeless shelters, drop-in centers or the street. **The essential element of all outreach activity is the outreach worker having contact with a prospective client and making a referral** for any of the following services: (CT, STD Screening & Testing, ILI, GLI, or PCM). There are three **types** of outreach activities: ▪ *Materials distribution* – involves the **direct** distribution of HIV prevention information and other risk reduction materials and may include a referral to a service provider or agency. ▪ *Recruitment* – the main purpose of this type of outreach is to bring an individual into a service provider or agency. ▪ *Encounter* – outreach for the purpose of providing risk reduction or skills building HIV prevention services and may include a referral to other services. For each of these types of outreach there are three **methods** or ways outreach workers generally establish contact with clients: ▪ *Active street outreach* – outreach workers move down a street, screening and engaging prospective clients for the purposes of delivering risk reduction information, materials such as condoms and bleach kits, for making referrals, and for actively taking clients to referred services. ▪ *Fixed site outreach* – outreach activities conducted at a specific place at a specific location also for the purposes of delivering risk reduction information, materials such as condoms and bleach kits, for making referrals, and for actively taking clients to referred services.

	▪ *Drop*-off site outreach – outreach activities which provide risk reduction materials to a second party who in turn distributes these materials. This should not be considered an intervention in and of itself and should be reported on the Community Level Intervention Report Form. **Additional definitions:** ***Contacts*** – face to face interactions to include a more in-depth assessment of the person's needs. ***Accessed*** – clients who receive an outreach referral to one of the following services CT, STD Screening & Testing, ILI, GLI, or PCM, and make contact (face-to-face) with a representative of the service agency. ***Referred*** – client is provided with a referral to obtain a specific (time, place, date) prevention service, which may include HIV testing or other health education risk reduction activities. This referral can be either a passive referral or an active referral. ***Active referral*** – direct linkage (access) to a service provider or agency, (i.e., transporting the client to the agency). ***Passive referral*** – information about a prevention activity or service provider is given to a prospective client during an outreach contact. The prospective client must take the next step to access that service. ***Passive referral with agency verification*** – confirmation by the service provider subsequent to the referral that the prospective client received services. ***Passive referral with client verification*** – confirmation by the client at the time of service that he/she was referred to the service provider or agency.

Health Communication/Public Information

The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain specific services. *(See table below for further definition of Health Communication/Public Information types)*

- Report Health Communication/Public Information activities using the Health Communication/Public Information Report Form.
- If the activity is a presentation or a health/community fair booth report activity details on the *Health Communications Presentation/Activity Log*

Health Communication/Public Information	**Presentations/Lectures:** These are information-only activities conducted in group settings; often called “one-shot” or “HIV 101” education interventions **Health/Community Fairs** – To set up information tables or booths which may include interactive activities for the purpose of disseminating information verbally and written to the general public and/or high-risk populations. Health/community fairs raise awareness and assist in building relationships within a community. May be used as a vehicle to recruit persons for other services/programs. **Electronic Media:** Means by which information is electronically conveyed to large groups of people; includes radio, television, public service announcements, news broadcasts, infomercials, etc., which reach a large-scale (e.g., city-, region-,or statewide) audience. **Print Media:** These formats also reach a large-scale or nationwide audience and includes any printed material, such as newspapers, magazines, pamphlets, and “environmental media” such as billboards and transportation signage. **Hotline:** Telephone service (local or toll-free) offering up-to-date information and referral to local services (e.g., counseling/testing and support groups). **Clearinghouse:** Interactive electronic outreach systems using telephones, mail, and the Internet/Worldwide Web to provide a responsive information service to the general public as well as high-risk populations.

Section IV – Reporting Requirements

Process Monitoring/Behavioral Monitoring

Each heading below lists the Process Monitoring Forms required for reporting intervention activities. In order to receive payment for contracted activities billed, the forms below must accompany the invoice submitted to the STD/AIDS Program. The STD/AIDS Program reimburses workplan activities on a fee for service basis. The Process Monitoring forms provide the necessary documentation to support the completion of activities outlined in the contract agency's workplan.

I. Prevention Case Management
(See Attachment F – Reporting Forms PCM, ILI, and client level outreach)

a. *Individual Level Program Participant Form*
b. *HIV Individual Level Prevention Intervention: Intervention Session Details* (refer to PEMS Activity List for codes to describe session activities)
c. *Risk Reduction Plan (See Protocols for Behavioral Outcome Monitoring)*
d. Client Behavior Details for ILI and PCM

II. Individual Level Intervention
(See Attachment F – Reporting Forms PCM, ILI, and client level outreach)

a. *Individual Level Program Participant Form*
b. *HIV Individual Level Prevention Intervention: Intervention Session Details* (refer to HE/RR and Outreach Activity List for codes to describe session activities)
c. *Risk Reduction Plan (See Protocols for Behavioral Outcome Monitoring)*
d. Client Behavior Details for ILI and PCM

III. Group Level Intervention
(See Attachment G – Reporting Forms Group Level Intervention)

a. *HIV Prevention Program Participant Form I* (form includes Pre intervention HIV Risk Behavior Questionnaire)
b. *HE/RR Group-Level Intervention-Session Report Form* (refer to PEMS Activity List for codes to describe session activities)
c. *HIV Prevention Participant Sign-In Form*
d. *HIV Risk Behavior Questionnaire II* (completed at last session)
e. *Permission to Contact Form* (for local use-please do not submit to STD/AIDS Program)
f. *HIV Risk Behavior Questionnaire III* (sent 30 days post intervention)

IV. Outreach Interventions (repeated direct contact with participants for risk reduction)
(See Attachment F – Reporting Forms PCM, ILI, and client level outreach)

a. *Individual Level Program Participant Form*

b. *HIV Individual Level Prevention Intervention: Intervention Session Details* (refer to PEMS Activity List for codes to describe session activities)

c. *Risk Reduction Plan (See Protocols for Behavioral Outcome Monitoring)*

d. Client Behavior Details for ILI and PCM

V. Outreach Interventions Non-HE/RR (no risk reduction performed)
(See Attachment H – Report Form for Outreach)

a. *Outreach Intervention Report Form* (refer to Activity List for codes to describe session activities)

VI. Health Communication/Public Information Interventions
(See Attachment I – Reporting Forms for Health Education/Public Information)

a. *Health Communication/Public Information Intervention Report Form* (refer to Activity List for codes to describe activities)

b. If HC/PI was a presentation or lecture, also submit *Health Communications Presentations/Lectures Log Form*.

VII. Other Community-Level Interventions

If the intervention is not comprised of activities that can be reported on HE/RR, Outreach, or HC/PI report forms use the *Other Community-Level Intervention (CLI) Report Form* to describe activities, there dates, staff involved, and outcomes generated from the activities. See Attachment J – Report Form CLI.

Quarterly Reports

All HIV Prevention contractors will submit a quarterly report using the STD/AIDS Program quarterly report template. The report is due 30 days after the end of the quarter. See Attachment K – Quarterly Report Template.

End of Year Evaluation

Contractors conducting HE/RR interventions are required to submit a year end evaluation due on the date specified in the contract. In the year end evaluation the contractor will report on progress in achieving workplan goals and objectives.

Section V – Behavioral Monitoring Protocols

Health Education and Risk Reduction

Contractors conducting HIV Prevention Health Education/Risk Reduction (HE/RR) interventions are required to conduct behavioral outcome monitoring as directed by the STD/AIDS Program behavioral outcome monitoring protocols.

Group Level Interventions

For group level interventions, behavioral outcomes will be measured at three different points in time: intake, end of intervention, and 30-60 days post intervention, using the forms provided by the STD/AIDS Program. The forms are located in Attachment G of this guide.

The data collected from these instruments will be analyzed by the STD/AIDS Program and used to assess performance indicators reported to the Division of Health. Data summaries will be provided to contractors at the end of the 2nd and 4th quarters of the contract year. The following performance indicators will be assessed:

PI 1.0 At the end of the intervention, 75% of participants who indicate at pretest they had multiple sex partners in the last 3 months, will indicate they will (or have) reduce(d) the number of sex partners.

PI 1.1 Of participants who indicated at pretest they had multiple sex partners in the last 3 months, 50% will report fewer sex partners at the 30-day follow-up.

PI 2.0 Of the participants at pre test who indicated they had multiple partners and did not use a condom the last time they had sex, 50% will indicate at the 30-day follow-up they used a condom the last time they engaged in sex (anal or vaginal intercourse).

PI 3.0 For participants who indicated no to confidence in condom use, 75% will indicate confidence in condom use at the end of the intervention.

PI 3.1 For participants who indicated no to confidence in condom use, 50% will indicate an increase in the frequency of condom use at 30 days following the intervention.

PI 4.0 For participants who indicate at the end of the intervention they will increase condom use, 75% will report an increase in condom use (vaginal, anal, or both) at the 30-day follow-up over reported use at the beginning of the intervention.

PI 5.0 By the end of the intervention, 90% of individuals enrolled in group-level interventions with a condom practice component will have demonstrated proper use of a condom through placement of condom on a prop or other approved method.

PI 6.0 Of those participants that indicated they shared unclean syringe and drug injection equipment at pre test, at the 30-day follow-up 50% of those who used injection drugs within the last 30 days will indicate that they used sterilized or new drug injection equipment the last time they used.

When administering questionnaires to clients, providers should emphasize the importance of the information being collected. The information provides support for continuing HIV prevention programs in the state of Idaho and helps to determine ways programs can be improved. Please assure clients that the information collected is confidential and that agencies who use the data will not know their identity.

Pre-Test Behavior Monitoring for HE/RR Group Level Interventions

Risk behavior questions included on *HIV Prevention Program Participant Form I* will be asked of each client at the first session of all group-level (GLI) interventions before the client receives any of the prevention core elements. A provider must have approval from STD/AIDS Program staff to administer this questionnaire other than at the first session.

Incarcerated participants should be instructed to report on behaviors during the 90 days prior to incarceration or the last 90 days in which they were sexually active.

Completed questionnaires are to be submitted to the STD/AIDS Program with monitoring forms that support activities as they are billed.

End-of-Intervention Post-Test Monitoring

A second behavioral outcome measure (*HIV Risk Behavior Questionnaire II*) will be taken at the end of the intervention (last scheduled session) measuring the participant's intent to change, steps they have taken to change behavior that puts them at risk for HIV infection or they are asked to identify barriers to change.

The end of intervention questionnaire also asks participants to rate the quality of the facilitator and to give feedback about program improvement.

Completed questionnaires are to be submitted to the STD/AIDS Program at the time the last session of the intervention cycle is billed.

Obtain *Permission to Contact Form* from participants for the purpose of sending a follow-up risk behavior questionnaire (see below).

30- 60-Day Post-Intervention/Incarceration Follow-Up Behavior Monitoring

For participants not incarcerated at the time of the intervention, a follow-up questionnaire will be sent to the participant 30-days following the end of the HIV prevention intervention. Contractors will be responsible to collect follow-up contact information from the participant before the end of the intervention. It is highly recommended that contractors collect *Permission to Contact Forms* from participants on the last day of the intervention at the time the *End of Intervention Behavioral Risk Questionnaire* is administered. Because these permission forms contain identifying information, protocols for storing confidential client information must be followed.

Please explain to your participants that agreeing to be contacted and completing the Follow-up Behavioral Risk Questionnaire is voluntary. However, please stress to participants that the information is confidential and will give us evidence to show funding agencies the importance of providing programs like the one they attended. Assure participant's that the agency analyzing and using the data will not know their identity.

If the participant was incarcerated at the time the intervention was delivered, a follow-up questionnaire should be sent 30-days after their release. The contractor will be responsible for networking with Department of Correction's staff to ascertain when a participant has been released. Protocols for storing confidential client information must be followed. On the last day of the intervention please follow the same protocols as detailed for non-incarcerated participants. Just acknowledge that the questionnaire will be sent after release.

At follow-up, all participants will be sent the same behavioral measurement instrument that inquires about their HIV Risk Behaviors in the last 30-days. The provider will be responsible to mail the questionnaire and a postage paid return envelope to the participant being sensitive to issues of confidentiality.

The participant will be instructed to complete and return the questionnaire in the self-addressed stamped envelop provided. The STD/AIDS Program will provide the self-addressed stamped envelopes to contractors with the Bureau of Clinical and Preventative Services address.

Prevention Case Management and Individual Level Interventions

Behavioral outcomes for prevention case management (PCM) and individually delivered interventions will be assessed by tracking client progress on Personal Risk Reduction Plans. The following are the performance indicators that will be monitored by the STD/AIDS Program and reported to the Division of Health.

PCM PI 1.0 100% of clients enrolled in either PCM or ILI will have a Personal Risk Reduction Plan that specifies HIV and STD risk reduction goals, includes a way to measure the goals and a time frame upon which to complete these goals

PCM PI 2.0 50% of PCM clients will achieve the goals listed on their behavior change plan within the time frame indicated or by the end of the intervention. The standard by which to measure achievement of goal is determined by the client and risk reduction counselor at the beginning of the intervention. (If the client has multiple goals to be achieved at different time frames, the intervention is complete when all goals have been completed)

The protocols for PCM and ILI are outlined in Section III and describe the reporting and monitoring requirements. Behavioral risk for PCM and ILI clients will be gathered through completion of the *Individual Level Program Participant Form* and *Client Behavior Details* form and reported to CDC through the Program Evaluation and Monitoring System.

Attachment A – Factors That Influence Behavior

Factors that Influence Behavior (FIBs)

FIB	Definition and Example
Communication and Negotiation	Definition: comfort levels and skills related to talking to a partner about sexual practices, condom use, drug use, or disclosure of HIV status. Example: "I carry a condom, but I don't really know how to mention it or when to pull it out."
Cultural Norms	Definition: ideas about what is and is not acceptable or normal behavior for men and women surrounding sexuality and decision making; may involve family and religious ideas and practices Example: "There's nothing I can say or do about his other girlfriends. That's just the way it is."
Environmental Barriers or Facilitators	Definition: the lack of goods and services that would make it possible or easier for a person to reduce risky behavior or public policy and laws that encourage or discourage risky behaviors Example: "I couldn't get a clean point because the pharmacy wouldn't sell me one."
Fatalism	Definition: a belief that circumstances are beyond one's control Example: "If you're going to get it, you're going to get it. Why bother?"
Group Norms	Definition: individual attitudes and behaviors that influence the attitudes and behaviors of members in the same peer group Example: "Everybody I know smokes or drinks a little and ends up having sex."
Intentions	Definition: a plan to perform a specific behavior Example: "I'm going to buy condoms the next time I'm at the store and show them to my boyfriend."
Interpersonal Power Dynamics: coercion, sex for drugs	Definition: within couples, the inability to discuss or initiate change to reduce risky behavior due to a lack of comfort or an inequality of power; inequalities may result in forced sex or an exchange of sex for other commodities, such as drugs, food, etc. Example: "If I asked him to use a condom, he would hurt me."

FIB	Definition and Example
Perceived Severity	Definition: a belief that HIV/AIDS may not be threatening because of advances in available treatments; a belief that the threat of infection is a less severe outcome than not being able to engage in the risky behavior Example: "If I get something, I just go to the clinic and get a shot. Besides, I know people who are HIV positive and they look fine.
Perceived Susceptibility	Definition: a personal belief that one is not at risk, so it is okay to engage in high-risk behavior Example: "I'm not gay, so I don't worry about getting AIDS."
Problem Hierarchy	Definition: an individual's immediate needs (housing, food, children, a job, ect.) that force the concern for HIV/AIDS into the background Example: "Forget condoms. I need a job."
Self-Efficacy	Definition: the degree of confidence a person has about being able to perform a specific behavior Example: "I just don't think I can be that careful every time."
Self-Esteem	Definition: a person's sense of being wanted and/or valued despite imperfections Example: "I have sex because it makes me feel grown up."
Sexual Arousal	Definition: the ability to avoid risky behavior in conditions of sexual arousal Example: "My pleasure is driven by the moment. There isn't any planning."
Shame and Guilt	Definition: emotions often stemming from stigmas associated with sexuality that can trigger high-risk sexual behavior. Example: "People already think I'm too young to be having sex, so who can I ask for condoms?"

Attachment B – Workplan Templates

Workplan/Program Information *(Complete for each Program Model)*						
Agency Name: **Program Name:** **Program Model Name:** **Community Planning Year this Program was initiated:**						
Basis for Your Program Model—*the basis of your program model will fit into ONE of the three categories listed below—refer to Attachment C of the Workplan Guidance to complete this section of the workplan*						
☐ **Study Replication Model:**						
☐ **Procedural Guidance:**						
☐ **Other Basis for Program Model:** Please attach on a separate sheet an explanation of the scientific, theoretical or operational basis for the program. If applicable, specify the published article or study upon which this program is modeled, or briefly describe the source of the model for the program. If the program is not based on another model, please use a logic model format to describe the planning and evaluation process for the intervention.						
Goal Statement--*a broad statement that clearly defines the intent of the intervention over the planned life of the intervention. (See Section I of Contractor's Guide: Writing a Goal Statement).*						
Target Population:	☐ HIV +	☐ MSM	☐ High Risk Heterosexual	☐ Injection Drug User	☐ Youth	☐ Other (specify): _____

Workplan/Health Education and Risk Reduction Intervention Plan
(Must be linked to a program model)

Agency:

Program Name:

Program Model Name:

Intervention Name:

Intervention Type (select one):			
☐ Individual-Level Intervention	☐ Group-Level Intervention	☐ Prevention Case Management (PCM)	☐ One-to-one Outreach (Encounter)

HIV+ Intervention: ☐ Yes ☐ No	**Planned Number of Cycles:** _____ Cycle(s) **Number of Sessions:** _____ Session(s) **Duration of Session:** _____ minutes	**Duration of Intervention Cycle:** _____ Month(s) or _____ Day(s)

Estimated number of clients to be reached this year for target population(s) indicated under the program model:	Estimated # for primary target population Estimated # for secondary target population	**Level of Data Collection:** ☐ Individual ☐ Aggregate	**Risk Behavior Data-Collection:** ☐ **Yes** ☐ **No** **If Yes, Specify Recall Period at Intake:** ☐ 90 days **and** ☐ 15 days ☐ 30 days **Recall Period after Intake:** ☐ 15 days ☐ 30 days

Unit of Delivery:	**Delivery Method:**		
☐ Individual ☐ Couple ☐ Small Group ☐ Large Group ☐ Community	☐ In person ☐ Internet ☐ Printed Materials-magazines/newspapers ☐ Printed Materials-pamphlets/brochures	☐ Printed Materials-posters/billboards ☐ Radio ☐ Telephone	☐ Television ☐ Video ☐ Other (specify)_____

Language of Intervention Delivery: ☐ English ☐ Spanish ☐ Other Language(s)

Activity Information: *Use the Contractor's Guide Attachment D to identify the activities to be performed during each session of the intervention. More sessions may be added if necessary.*	
Session one	
Session two	
Session three	
Session four	
Session five	
Session six	

Behavioral Objective(s) of intervention: *The change in the priority population's behavior that needs to occur in order to attain the intervention's goal. See Section I of the Contractor's Guide on using the SMART method to write objectives.*

Outcome objectives(s)*: What are the intended changes in risk or protective factors (attitudes, knowledge, beliefs, and skills) associated with the behavioral outcome? (See Section I of the Contractor's Guide for writing outcome objectives using the SMART Method.)*		
Site Information*: If the intervention takes place somewhere other than the agency location, please complete to describe the site where services are planned and/or delivered. See Contractor's Guide Attachment E for site types.*		
Site Name:		
Site Type:		
Address:		
County:		
Phone:	Fax:	Email:
Site Contact's First Name, Last Name, & Title:		

Workplan/Non-HE/RR Outreach
(Must be linked to a program model)

Agency: **Program Model Name:**

Program Name: **Intervention Name:**

Outreach Type: ☐ Materials Distribution ☐ Recruitment

Outreach Method: ☐ Active Street ☐ Fixed Site ☐ Drop-off site

HIV+ Intervention:

☐ Yes ☐ No

Planned Number of Cycles:

_____ Cycle(s) ☐ Ongoing

Number of Sessions:

_____ Session(s) ☐ Unknown

Duration of Session:

_____ Minutes ☐ Unknown

Duration of Intervention Cycle:

_____ Day(s)

Estimated number of clients to be reached this year for target population(s) indicated under the program model:

Estimated Primary Target = _____ If Secondary Target, Estimated Target = _____

Unit of Delivery:

☐ Individual
☐ Couple
☐ Small Group
☐ Large Group
☐ Community

Delivery Method:

☐ In person
☐ Internet
☐ Printed Materials-magazines/newspapers
☐ Printed Materials-pamphlets/brochures
☐ Printed Materials-posters/billboards
☐ Radio
☐ Telephone
☐ Television
☐ Video
☐ Other (specify)_____

Language of Intervention Delivery: ☐ English ☐ Spanish ☐ Other Language(s) _____

Activity Information: *Describe the activities associated with this outreach intervention. See Contractor's Guide Attachment D for activity codes.*

Process Objective(s) of intervention: *See Section I of the Contractor's Guide for writing Process Objectives.*		
Site Information: *Please complete for each outreach site associated with intervention. See Attachment E of the Contractor's Guide for site types.*		
Site Name:		
Site Type:		
Address:		
County:		
Phone:	Fax:	Email:
Site Contact's First Name, Last Name, & Title:		
Site Name:		
Site Type:		
Address:		
County:		
Phone:	Fax:	Email:
Site Contact's First Name, Last Name, & Title:		

Workplan/Health Communication /Public Information
(Must be linked to a program model)

Agency:

Program Name:

Program Model Name:

Intervention Name:

HIV+ Intervention: ☐ Yes ☐ No	**Planned Number of Cycles:** _____ **Cycle(s)**	**Duration of Intervention Cycle:** _____ Month(s) or _____ Day(s)

Estimated number of clients to be reached this year for target population(s) indicated under the program model:

Estimated Primary Target = _____ If Secondary Target, Estimated Target = _____

Unit of Delivery:

☐ Individual
☐ Couple
☐ Small Group
☐ Large Group
☐ Community

Delivery Method:

☐ In person
☐ Internet
☐ Printed Materials-magazines/newspapers
☐ Printed Materials-pamphlets/brochures
☐ Printed Materials-posters/billboards
☐ Radio
☐ Telephone
☐ Television
☐ Video
☐ Other (specify)_____

Language of Intervention Delivery: ☐ English ☐ Spanish ☐ Other Language(s)

Activity Information: *Describe the activities associated with this intervention. See Contractor's Guide Attachment D for activity codes.*

Process Objective(s) of intervention:		
Site Information*: Please complete for each site associated with intervention. See appendix E for site types.*		
Site Name:		
Site Type:		
Address:		
County:		
Phone:	Fax:	Email:
Site Contact's First Name, Last Name, & Title:		
Site Name:		
Site Type:		
Address:		
County:		
Phone:	Fax:	Email:
Site Contact's First Name, Last Name, & Title:		

Workplan/Community Level Interventions			
Agency Name: **Program Model Name:** **Intervention Name:**			
Describe how this intervention is linked to the Program Model and/or HIV prevention goal(s) of the agency.			
Check type of CLI: ☐ Community mobilization ☐ Social marketing campaign ☐ Community-wide event ☐ Policy intervention ☐ Structural intervention ☐ Other _____			
Objective(s) of the Intervention:			
Activities	Person(s) and Agencies Involved **Who** will see that it's done?	**When** will it be done?	**How** will you show it was done?

Attachment C – Basis for Program Models

Study Replication Models

Programs proven effective through research studies that have shown positive behavioral and/or health outcomes.

If using a DEBI model, PEMS requires that your program maintain fidelity with the original model for reporting purposes. According to the *Procedural Guidance* drafted in December 2003, for a program model to maintain fidelity the Core Elements of the intervention must be maintained.

**Additional models are listed in the Compendium*: www.cdc.gov/hiv/pubs/HIV_compendium.htm

Community PROMISE
Healthy Relationships
Holistic Harm Reduction Program
Many Men, Many Voices
Mpowerment
Popular Opinion Leaders
RAPP
Safety Counts
SISTA
Street Smart
Teens Linked to Care
VOICES/VOCES
Partnership for Health
Project RESPECT

Procedural Guidance

If a Study Replication Model cannot be considered the basis for a program model, then select from the list of CDC procedural guidelines that were used

*Procedural Guidance Documents: www.cdc.gov/hiv/partners/ahp.htm

Prevention Case Management-For HIV infected persons

Other Basis for Program Model

Interventions with insufficient evidence of effectiveness, but based on prior outcome monitoring data suggesting positive effects, but that cannot be rigorously proven; based on sound science and theory; based on a logic model that matches the science and theory to the intended outcomes of interest; and where the logic model matches with relevant behavioral-epi data from their community & target population.

Interventions with insufficient evidence of effectiveness, and no prior outcome monitoring data available; based on sound science and theory; based on a logic model that matches the science and theory to the intended outcomes of interest; and where the logic model matches with relevant behavioral-epi data from their community & target population.

Attachment D – PEMS Intervention Activity List

PEMS Activity List HE/RR level interventions choose from all activities Health Communications/Public Information (HC/PI) choose from activities with asterisk *	
4.0*	**Referral** – a process by which immediate client needs for prevention, care, and supportive services are assessed and prioritized and clients are provided with information and assistance in identifying and accessing specific services (setting up appointment, providing transportation**) Note: The provision of a referral also includes a plan for tracking whether or not the client accessed the referral.**
5.0	**Personalized risk assessment** – the process by which an individual client, a provider, or both working together identify, acknowledge, and understand the details and context of the client's HIV risk. The assessment should explore previous risk reduction efforts and identify successes and challenges of those efforts.
Information	
8.01*	**Information-HIV/AIDS transmission and risk reduction**-Any general information, written or verbal, given to an individual or a group on HIV/AIDS and how it is transmitted.
8.02*	**Information-HIV risk free behavior**-Any information, written or verbal, given to an individual or a group on abstaining from sexual activity or postponing sexual activity.
8.03*	**Information-Other sexually transmitted diseases**-Any information, written or verbal, given to an individual or a group on STDs (other than HIV or viral hepatitis), how it is transmitted, how to reduce risk for transmission or infection, or treatment options.
8.04*	**Information-Viral hepatitis**-Any information on viral hepatitis, how it is transmitted, and/or how to reduce risk for transmission or infection, or treatment options.
8.05*	**Information-Availability of HIV/STD counseling and testing**-Any information, written or verbal, given to an individual or a group about where and how to access HIV-related CTR or STD counseling and testing. This includes referral lists that only list CTR and/or STD counseling and testing sites.
8.06*	**Information-Availability of Partner notification and referral services**-Any information, written or verbal, given to an individual or a group about where and how to access partner notification services. The availability information provided is exclusive to PCRS. This includes referral lists that only list PCRS sites.
8.07*	**Information-Living with HIV/AIDS**-Any information, written or verbal, given to an individual or a group living with HIV/AIDS specific to living with the disease.
8.08*	**Information-Availability of social services**-Any information, written or verbal, given to an individual or a group about how and where to access social services. This could include a referral list that only includes social service agencies or providers.
8.09*	**Information-Availability of medical services**-Any information, written or verbal, given to an individual or a group about how and where to access HIV medical services. This could include a referral list that only includes HIV medical care providers.
8.10*	**Information-Sexual risk reduction**-Any information, written or verbal, given to an individual or a group on how to reduce sexual risk for HIV transmission.
8.11*	**Information-IDU risk reduction**-Any information, written or verbal, given to an individual or a group on how to reduce injection drug use risk for HIV transmission or infection.
8.12*	**Information-IDU risk free behavior**-Any information, written or verbal given to an individual or a group on abstaining from injection drug use or only using new needles and disposing of them appropriately.
8.13*	**Information-Condom/barrier use**-Any information, written or verbal, given to an individual or a group regarding appropriate use and disposal of condoms or other barrier methods.
8.14*	**Information-Negotiation/Communication**-Any information, written or verbal, given to an individual or a group regarding communication of desire for safer practices and negotiating safer practices with partners (sexual and needle sharing).
8.15*	**Information-Decision making**-Any information, written or verbal, given to an individual or a group regarding the steps and techniques needed for reassessing, planning and using judgment to avoid situations that may expose them to HIV infection or transmission risk and/or decision to engage in a risk behavior.
8.16*	**Information-Disclosure of status-**Any information, written or verbal, given to an individual or a group regarding disclosure of their HIV status, applicable laws, accompanying ramifications, and options regarding non-disclosure.
8.17*	**Information-Providing prevention services**-Any information, written or verbal, given to an individual or a group on how to communicate prevention messages and/or demonstrate risk reduction skills with others.

8.18*	**Information-HIV testing**-Any information, written or verbal, given to an individual, couple, or group regarding HIV testing including explanation of the testing process and meaning of results, behavioral risks for infection, and importance of knowing their status.
8.19*	**Information-Partner notification**-Any information, written or verbal, given to an individual or a group regarding the notification of possible exposure to HIV and accompanying ramifications, behaviors associated with possible exposure, and consideration of alternatives or information on how to notify partners regarding possible exposure.
8.20*	**Information-HIV medication therapy adherence**-Any information, written or verbal, given to an individual or a group regarding HIV medication therapy, benefits and risk, medical therapy alternatives, and importance of adhering to medication therapy for HIV.
8.21*	**Information-Alcohol and drug use prevention**-Any information, written or verbal, given to an individual or a group on the negative effects and consequences of alcohol and drug use and its relationship to HIV transmission or infection risk behavior including strategies to avoid or abstain from use.
8.22*	**Information-Sexual health**-Any information, written or verbal, given to an individual or a group on reproductive health, sexuality, sexual development and similar topics.
8.66*	**Information-Other**-Any information, written or verbal, given to an individual or group that cannot be captured in any of the other information codes.
Demonstration	
9.01*	**Demonstration-Condom/barrier use**-Provider or participant demonstration (using a teaching tool) of appropriate use and disposal of condoms or other barrier methods.
9.02*	**Demonstration-IDU risk reduction**-Provider or participant demonstration of how to safely dispose of syringes or how to use bleach kits to clean works.
9.03*	**Demonstration-Negotiation/Communication**-Provider or participant demonstration of how to communicate desire for safer practices and how to negotiate safer practices with partners (sexual and needle sharing).
9.04*	**Demonstration-Decision making**-Provider or participant demonstration of steps, and techniques needed for reassessing, planning and using judgment to avoid situations that may expose them to HIV infection or transmission risk and/or decision to engage in a risk behavior.
9.05*	**Demonstration-Disclosure of HIV status**-Provider or participant demonstration of techniques to disclose seropositive status or discuss issues relevant to disclosure.
9.06*	**Demonstration-Providing prevention services**-Provider or participant demonstration of how to communicate prevention messages or demonstrate risk reduction skills with others.
9.07*	**Demonstration-Partner notification-**Provider or participant demonstration of how to notify partners regarding possible exposure to HIV or how to discuss issues relevant to partner notification.
9.66*	**Demonstration-Other**-Any provider or participant demonstration of a skills or technique that is not decision making, IDU risk reduction, condom/barrier use, negotiation and communication, disclosure, or providing prevention services.
Practice	
10.01	**Practice-Condom/barrier use**-Participant practice (using a teaching tool) of appropriate condom and/or barrier use and disposal during the intervention session.
10.02	**Practice-IDU risk reduction**-Participant practice of safe needle use and disposal including the use of bleach kits to clean works during the intervention session(s).
10.03	**Practice-Negotiation and communication**-Participant practice communication of desire for safer practices and negotiation of safer practices with partners (sexual and needle sharing during the intervention session(s).
10.04	**Practice-Decision making**-Participant practice using steps and techniques needed for reassessing, planning and using judgment to avoid situations that may expose them to HIV infection or transmission risk and/or decision to engage in a risk behavior.
10.05	**Practice-Disclosure of HIV status**-Participant practice of techniques to disclose seropositive status or discuss issues relevant to disclosure.
10.06	**Practice-Providing prevention services**-Participant practice communication of prevention messages and/or demonstration of risk reduction skills with others during intervention session(s).
10.07	**Practice-Partner notification**-Participant practice of how to notify partners regarding possible exposure to HIV or how to discuss issues relevant to partner notification.
10.66	**Practice-Other**-Participant practice of a skill or technique that is not decision making, IDU risk reduction, condom/barrier use, negotiation and communication, disclosure, or providing prevention services.

Discussion	
11.01*	**Discussion-Sexual risk reduction**-Facilitation of discussion with individuals or groups involving examination of sexual risk behaviors (self or others)and accompanying ramifications, examination of attitudes and feelings about their risks, consideration of alternatives, and decision making to reduce sexual risk.
11.02*	**Discussion-IDU risk reduction**-Facilitation of discussion with individuals or groups involving examination of IDU risk and accompanying ramifications, examination of attitudes and feelings about their risks, consideration of alternatives, and decision-making to reduce IDU risk.
11.03*	**Discussion-HIV testing**-Facilitation of discussion with individuals, couples, or groups regarding HIV testing including explanation of the testing process and meaning of results, discussion of behavioral risks for infection, examination of attitudes and feelings about their risks, consideration of alternatives, and decision making to know their status and reduce HIV transmission risk.
11.04*	**Discussion-Other sexually transmitted diseases**-Facilitation of discussion with individuals or groups regarding sexually transmitted diseases (other than HIV), involving an examination of behavioral risks and accompanying ramifications, examination of attitudes and feelings about their risks, consideration of alternatives, treatment alternatives, and decision making to reduce behavioral risk for other sexually transmitted diseases and/or seek treatment.
11.05*	**Discussion-Disclosure of HIV status**- Facilitation of discussion with individuals or groups regarding techniques to disclose seropositive status or discuss issues relevant to disclosure.
11.06*	**Discussion-Partner notification**- Facilitation of discussion with individuals or groups regarding how to notify partners regarding possible exposure to HIV or how to discuss issues relevant to partner notification.
11.07*	**Discussion-HIV Medication therapy adherence**- Facilitation of discussion with individuals or groups regarding HIV medication therapy and accompanying ramifications, examination of attitudes and feelings about HIV medication therapy, discussion of medical therapy alternatives, and decision making to begin and adhere to medication therapy for HIV.
11.08*	**Discussion-Abstinence/postpone sexual activity**-Facilitation of discussion with individuals or groups on abstaining from sexual activity or postponing the initiation of sexual activity and accompanying ramifications including an examination of risks associated with sexual activities, discussion of alternatives, and decision making to abstain or postpone sexual activity.
11.09*	**Discussion-IDU risk free behavior**-Facilitation of discussion with individuals or groups on abstaining from injection drug use or only using new needles and disposing appropriately.
11.10*	**Discussion-HIV/AIDS transmission**-Facilitation of discussion with individuals or groups on HIV/AIDS and how HIV is transmitted.
11.11*	**Discussion-Viral hepatitis**-Facilitation of discussion with individuals or groups on viral hepatitis, how it is transmitted, and/or how to reduce risk for transmission or infection, or treatment options.
11.12*	**Discussion-Living with HIV/AIDS**-Facilitation of discussion with individuals or groups
11.13*	**Discussion-Availability of HIV/STD counseling and testing**-Facilitation of discussion with individuals or groups on where and how to access HIV-related CTR or STD counseling and testing and may include the importance of knowing your status. This includes referral lists that only list CTR and/or STD counseling and testing sites.
11.14*	**Discussion-Availability of partner notification and referral services**-Facilitation of discussion with individuals or groups on where and how to access partner notification services.
11.15*	**Discussion-Availability of social services**-Facilitation of discussion with individuals or groups on how and where to access social services.
11.16*	**Discussion-Availability of medical services**-Facilitation of discussion with individuals or groups on how and where to access HIV medical care. Discussion may include options regarding available services.
11.17*	**Discussion-Condom/barrier use**-Facilitation of discussion with individuals or groups on the appropriate use and disposal of condoms or other barrier methods and accompanying ramifications, examination of attitudes and feelings about condom use, and decision making regarding use of condoms/barriers.
11.18*	**Discussion-Negotiation/Communication**-Facilitation of discussion with individuals or groups on communication of desire for safer practices and negotiating safer practices with partners (sexual and needle sharing), including discussion of accompanying ramifications, examination of attitudes and feelings, and decision making regarding communicating and negotiating safer practices.
11.19*	**Discussion-Decision making**-Facilitation of discussion with individuals or groups on steps and techniques needed for reassessing, planning and using judgment to avoid situations that may expose them to HIV infection or transmission risk and/or decision to engage in a risk behavior.
11.20*	**Discussion-Providing prevention services**-Facilitation of discussion with individuals or groups on communicating prevention message and/or demonstrating risk reduction skills with others.

11.21*	**Discussion-Alcohol and drug use prevention**-Facilitation of discussion with individuals or groups on the negative effects and consequences of alcohol and drug use and its relationship to HIV transmission or infection risk including strategies to avoid or abstain from use.
11.22*	**Discussion-Sexual health**-Facilitation of discussion with individuals or groups on reproductive health, sexuality, sexual development, and similar topics.
11.66*	**Discussion-Other**-Discussion with individuals or groups regarding HIV infection, transmission, or risk reduction issues and accompanying ramifications, examination of attitudes and feelings about these issues, consideration of alternatives, and decision making to reduce HIV infection, transmission, or risk reduction. Issues do not fit any of the above categories.
Distribution	
13.01*	**Distribution-Male condoms**-Provision of male condoms by handing them out or placing them in a location to be accessed by consumers at no cost to the consumer.
13.02*	**Distribution-Female condoms**-Provision of female condoms by hading them out or placing them in a location to be accessed by consumers at no cost to the consumer.
13.03*	**Distribution-Safe sex kits**-Provision of packages that minimally contain a condom (male or female), lubricant, and instruction for proper use. May include other materials at no cost to the consumer.
13.04*	**Distribution-Safer injection/bleach kits**-Provision of packages that minimally contain a small bottle of bleach and needle cleaning instructions. Packages may include bottle caps for cookers, cotton, alcohol wipes, and bottles of water for rinsing needles. Materials are provided at no cost to the consumer.
13.05*	**Distribution-Lubricants**-Provision of water based lubricants at no cost to the consumer as part of HIV prevention activities.
13.06*	**Distribution-Education materials**-Provision of printed materials designed to be learning or teaching aids by handing them out, placing in a location to be accessed by consumers, or electronic dissemination at no cost to the consumer.
13.07*	**Distribution-Referral lists**-Provision of specific organizations that provide a specific set of HIV prevention, care, or support services with contact information. The agencies listed are known by the provider to be reliable sources for those services based on provider knowledge and experience. Lists may be disseminated by handing them out, placing them in a location to be accessed by the consumer, or emailed to consumers.
13.08*	**Distribution-Role Model Stories**-Provision of stories of individuals who have changed their behaviors or plan to change their behaviors to reduce their risk for HIV transmission or infection. Stories may be disseminated by handing them out, placing them in a location to be accessed by the consumer, or emailed to consumers.
13.66*	**Distribution-Other**-Provision of materials or supplies to consumers with the intent to decrease their risk for HIV transmission or infection and/or to improve health outcomes. Distribution may include dissemination in person, by placing materials in locations to be accessed by consumers, sent to consumers electronically or land mail. Does not include condoms, safer sex kits, bleach kits, lubricants, education materials, referral lists, or role model stories.
Post-Intervention Activities	
14.01	**Post-intervention follow up**-Individual or group meeting or contact with participant(s) of an intervention after the last session of the intervention to assess or discuss changes targeted by the intervention and/or revisions to risk reduction goals and/or strategies.
14.02	**Post-intervention booster session**-An intervention session conducted with participant(s) of an intervention after the last session to review and reinforce risk reduction skills and information addressed by the intervention.
88.88	**Other**

Attachment E – PEMS Site Types

PEMS Site types	
F01 In-patient Facility - A hospital or other health facility where services are provided to patients that reside within the facility while they are receiving those services.	
F01.01	In-patient Hospital
F01.50	In-patient – Drug/Alcohol Treatment
F01.88	In-patient Facility– Other (specify)
F01.99	In-patient Facility-Unknown
F02 Outpatient Facility – A health care facility where services are provided to patients that do not reside within that facility while they are receiving services.	
F02.03	Outpatient – Private Medical Practice
F02.04	Outpatient – HIV Specialty Clinic
F02.10	Outpatient – Prenatal/OBGYN Clinic
F02.12	Outpatient – TB Clinic
F02.19	Outpatient – Drug/Alcohol Treatment Clinic
F02.20	Outpatient – Family Planning
F02.30	Outpatient – Community Mental Health
F02.51	Outpatient – Community Health Clinic
F02.58	Outpatient – School/University Clinic
F02.60	Outpatient – Health Department/Public Health Clinic
F02.61	Outpatient – Health Department/Public Health Clinic – HIV
F02.62	Outpatient – Health Department/Public Health Clinic – STD
F02.88	Outpatient Facility – Other (specify)
F02.99	Outpatient Facility-Unknown
F03 Emergency Room	
F04.01 Blood Bank, Plasma Center	
F04.05 HIV Counseling & Testing Site – A facility or non-facility based setting where HIV prevention counseling and testing services are provided.	
F06 Community Setting – A defined area, environment or context in which a group of people live, work or congregate.	
F06.01	Community Setting-AIDS Service Organization – non-clinical
F06.02	Community Setting-School/Education Facility
F06.03	Community Setting – Church/Mosque/Synagogue/Temple
F06.04	Community Setting – Shelter/Transitional Housing
F06.05	Community Setting – Commercial-A business or commercial facility (e.g., beauty salon, grocery store, shopping center) where HIV prevention services may also occur.
F06.06	Community Setting – Residential Area – A primary residence that might include residential neighborhoods or the common areas of apartment complexes or housing developments.
F06.07	Community Setting – Bar/Club/Adult Entertainment
F06.08	Community Setting – Public Area – An area, environment or context that is open to the community as a whole such as a park or city street.
F06.09	Community Setting – Workplace – A location where a worker normally performs his/her job tasks or the businesses administrative offices. Use this site type for prevention services delivered to a particular employer's employees.
F06.10	Community Setting – Community Center – A facility where the members of a community can gather for social or cultural activities.
F06.12	Individual Residence – An individual's home or place of residence. If Individual Residence is chosen, no locating information (e.g., address) is collected.
F06.88	Community Setting – Other (specify)
F07 Correctional Facility	A penal or correctional facility, prison, jail detention center, community-based rehabilitation center, or any similar institution designed for the confinement or rehabilitation of criminal offenders.
F88 Other	Specify

Attachment F – Reporting Forms PCM, ILI, and Client Level Outreach

Individual Level Program Participant Form
(ILI-HE/RR, PCM and PCRS)

To be completed by provider at first session. Assure your client that their identity will remain anonymous and we use the client code to keep their participation confidential.

Contracting Agency:

Intervention Name:

The 1st & 3rd letter of first name: The 1st & 3rd letter of last name:	⇒	____ ____ ____ ____
Birthday (month/day/year):	⇒	____ / ____ /_____

Date Information Collected:	Age	State of Residence	Sex assigned at birth (fill in only one)
____/____/_____			O Male O Female

Current Gender
- O Male
- O Female
- O Transgender- MTF
- O Transgender- FTM

Ethnicity (fill in only one)
- O Hispanic or Latino
- O Non-Hispanic
- O Ethnicity Unknown
- O Refused to answer

Race
- O American Indian/Alaskan Native
- O Asian
- O Black or African American
- O Native Hawaiian or Pacific Islander
- O White
- O Don't know

Race Expanded (see PEMS Codes)

Incarcerated in last 90 days?
- O No
- O Yes
- O Not asked
- O Refused to answer

Sex Worker (sex for money last 90 days?)
- O No
- O Yes
- O Not asked
- O Refused to answer

Housing Status (type/s of living arrangements in last 90 days)
- O Permanent Housing
- O Non-permanent housing
- O Institution
- O Not asked
- O Refused to answer
- O Other
- O Don't Know

Previous HIV Test (self-reported)
- O No
- O Yes
- O Not asked
- O Refused to answer
- O Don't know

HIV Status: (self-reported)
- O Positive-self report
- O Negative-self report
- O Not asked
- O Refused to answer
- O Don't know

If negative, date of last test: _____/_____/_____

If positive, date of first HIV Positive test: _____/_____/_____

If positive, in medical care/treatment?
- O No
- O Yes
- O Not asked
- O Refused to answer
- O Don't know

If female, is client pregnant?
- O No
- O Yes
- O Not asked
- O Refused to answer
- O Don't know

In prenatal care?
- O No
- O Yes
- O Not asked
- O Refused to answer

Client Risk Factors (last 90 days)
Sex refers to anal or vaginal intercourse
- O Injection Drug Use
- O Sex with transgender
- O Sex with female
- O Sex with male
- O No risk identified
- O Not asked
- O Refused to answer
- O Other

Recent STD (treatable STD in last 90 days?)
syphilis, gonorrhea, or chlamydia
- O No
- O Yes-self report
- O Yes-laboratory confirmed
- O Not asked
- O Refused to answer
- O Don't know

Viral Hepatitis
- O No
- O Yes-self report Circle type: HBV HCV
- O Yes-laboratory confirmed Circle type: HBV HCV
- O Not asked
- O Refused to answer
- O Don't know

Additional Risk Factors (If risk involves sexual activity, these are additional factors to describe risk)
- O No additional risk info specified
- O Sex in exchange for drugs/money/something needed
- O Sex while high on illicit drugs
- O Sex with an IDU
- O Sex with HIV+ partner
- O Sex with partner of unknown status
- O Sex with partner who exchanges sex for drugs/money
- O Sex with partner who is a known MSM
- O Sex with anonymous partner
- O Sex with partner who is hemophiliac or transfusion/transplant recipient
- O Not asked
- O Refused to answer

HIV Individual Level Prevention Intervention

Intervention Session Details

To be completed by provider. Assure your client that their identity will remain anonymous and we use the client code to keep their participation confidential.

Session Date: _____/_____/_____	PCRS Case Number: _____ (leave blank if not PCRS)
Contracting Agency:	Intervention Name:

Client ID

Client's Unique ID: _____ _____ _____ _____ ____/____/_____

1st and 3rd letter of first & last name — birth month/day/year

Intended # sessions	Current session #	Duration of Session	Site (if different from agency)
O #_____ O unknown		_____ minutes	

Recruitment Source (only reported at first session)

O Agency O HC/PI O Self O Partner O Friend and/or family member O Other _____ O Don't know

Session Activities

___ **Information** (circle types)

8.01, 8.02, 8.03, 8.04, 8.05, 8.06, 8.07, 8.08, 8.09, 8.10, 8.11, 8.12, 8.13, 8.14, 8.15, 8.16, 8.17, 8.18, 8.19, 8.20, 8.21, 8.22, 8.66

___ **Demonstration** (circle types)

9.01, 9.02, 9.03, 9.04, 9.05, 9.06, 9.07, 9.66

___ **Practice** (circle types)

10.01, 10.02, 10.03, 10.04, 10.05, 10.06, 10.07, 10.66

___ **Discussion** (circle types)

11.01, 11.02, 11.03, 11.04, 11.05, 11.06, 11.07, 11.08, 11.09, 11.10, 11.11, 11.12, 11.13, 11.14, 11.15, 11.16, 11.17, 11.18, 11.19, 11.20, 11.21, 11.22, 11.66

___ **Distribution** (circle types)

13.01, 13.02, 13.03, 13.04, 13.06, 13.07, 13.08, 13.66

___ **Post-Intervention**

14.01, 14.02

Referral Information

Referrals made (this visit):

___ HIV testing
___ STD screening
___ Viral Hepatitis screening
___ TB testing
___ Substance abuse treatment
___ Medical care
___ Mental Health Services
___ Other HIV prevention services
___ Other support services (specify) _____

Referral Follow-up type:

☐ none
☐ Active
☐ Passive referral-agency verification
☐ Passive referral-client verification

Referral Outcome (from previous referral):

Risk Reduction Plan:

Client Behavior Details for ILI and PCM

(These data should be collected at intake, final session, and intermittently during an intervention, as appropriate.)

Client ID: _____ / / Date: / /

Behavioral Recall Period

○ 15 days ○ 30 days ○ 90 days

Risk factors during recall period (sex refers to anal or vaginal intercourse)

○ Injection drug use	○ Sex with a female	○ No risk identified
○ Sex with transgender	○ Sex with a male	○ Refused to answer
		○ _____

Number of risk behaviors reported during the recall period

The number of partners with whom the client has had anal or vaginal sex.	#_____ ○ Refused to answer ○ Don't know
The number of sex partners with serodiscordant (i.e. one sex partner is HIV negative and the other sex partner is HIV positive) or HIV status unknown the client has had during behavioral recall period.	#_____ ○ Refused to answer ○ Don't know
The number of sex partners whose HIV serostatus the client did not know and whose identity was also unknown to the client.	#_____ ○ Refused to answer ○ Don't know
The number of times that the client had anal or vaginal sex (protected and unprotected) during the recall period.	#_____ ○ Refused to answer ○ Don't know
The number of times the client had anal or vaginal sex (protected and unprotected) with a serodiscordant partner or partner whose serostatus was unknown in a specified behavioral recall period.	#_____ ○ Refused to answer ○ Don't know
The number of times that the client had unprotected anal or vaginal sex with any partner in a specified behavioral recall period.	#_____ ○ Refused to answer ○ Don't know
The total number of times the client had unprotected anal or vaginal sex with a serodiscordant partner or a partner whose HIV serostatus was unknown.	#_____ ○ Refused to answer ○ Don't know
The total number of times the client had unprotected anal or vaginal sex with a serodiscordant **male partner** or a **male partner** whose HIV status was unknown during the specified recall period.	#_____ ○ Refused to answer ○ Don't know
The total number of times the client had unprotected anal or vaginal sex with a serodiscordant **female partner** or a **female partner** whose HIV status was unknown during the specified recall period.	#_____ ○ Refused to answer ○ Don't know
The total number of times the client had unprotected anal or vaginal sex with a serodiscordant **transgender partner** or a **transgender partner** whose HIV status was unknown during the specified recall period.	#_____ ○ Refused to answer ○ Don't know
The number of times that the client shared needles/syringes in a specified behavioral recall period.	#_____ ○ Refused to answer ○ Don't know
The number of times that the client shared needles/syringes with a serodiscordant partner or partner whose HIV status was unknown during the specified recall period.	#_____ ○ Refused to answer ○ Don't know

Attachment G – Reporting Forms Group Level Intervention

HIV Prevention Program Participant Form I (completed at first session)				
The following information is needed to identify you as a participant in this program while maintaining your confidentiality.				
1st & 3rd letter of your **first name** _____ _____		1st & 3rd letter of your **last name** _____ _____		
Your birth date (month/day/year):	___/___/_____	Your age:	State of Residence:	
The following information will be used for reporting program participant demographics only.				
Gender (fill in only one)	**Ethnicity (fill in only one)**	**Race (fill in only one)**		
☐ Male ☐ Female ☐ Transgender-MTF ☐ Transgender-FTM	☐ Hispanic or Latino ☐ Non-Hispanic ☐ Ethnicity Unknown	☐ American Indian/Alaskan Native ☐ Asian	☐ Black or African American ☐ Native Hawaiian or Pacific Islander	☐ White ☐ Unknown ☐ _____

HIV Risk Behavior Questionnaire

We need your help! Your open and honest answers to the following questions will help us provide evidence that programs like this one make a difference in people's lives. We realize these questions are very personal, but please be assured that your answers are confidential and the people who use this information will not know your identity. Thank you for your help.

1. **Which best describes the number of different sexual partners you have had in the last 3 months?**

☐ 10 or more partners
☐ 7-9 partners
☐ 4-6 partners
☐ 2-3 partners
☐ 1 partner
☐ abstinent (no anal or vaginal intercourse)

2. **The last time you had sex (anal or vaginal intercourse); did you or your partner use a condom?**

☐ No ☐ Yes ☐ Never had sex

3. **If asked to demonstrate how to use a condom correctly, do you feel confident that you can do this?**

☐ No ☐ Yes

4. **Thinking back over the last 3 months, which best describes your use of condoms for vaginal intercourse?**

☐ Did not have vaginal intercourse
☐ Never used condoms
☐ Used condoms at least 25% of the time
☐ Used condoms at least 50% of the time
☐ Used condoms at least 75% of the time
☐ Used condoms 100% of the time

5. **Thinking back over the last 3 months, which best describes your use of condoms for anal intercourse?**

- ☐ Did not have anal intercourse
- ☐ Never used condoms
- ☐ Used condoms at least 25% of the time
- ☐ Used condoms at least 50% of the time
- ☐ Used condoms at least 75% of the time
- ☐ Used condoms 100% of the time

6a. **Have you ever used injection drug equipment (including syringes, needles, cookers, & cottons)?**

- ☐ No (skip 6b and 6c)
- ☐ Yes (please answer 6b and 6c)

6b**. If yes, when was the last time you <u>shared</u> or used <u>unclean</u> drug injection equipment?**

- ☐ Within the last 30 days – As best as you can recall, how many times did you use within this time?
  ☐ 1 time ☐ 2-5 times ☐ 6-9 times ☐ 10-19 times ☐ 20-29 ☐ 30 and over
- ☐ Within the last 3 months – As best as you can recall, how many times did you use within this time?
  ☐ 1 time ☐ 2-5 times ☐ 6-9 times ☐ 10-19 times ☐ 20-29 ☐ 30-49 ☐ 50 and over
- ☐ More than 3 months ago
- ☐ More than 6 months ago
- ☐ Over 1 year ago
- ☐ I've never shared drug injection equipment

6c**. Of the following, which best describes the last time you used?**

- ☐ shared or reused unclean syringe and injection equipment
- ☐ used new, sterile drug injection equipment
- ☐ shared disinfected syringe (cleaned with bleach) and used new cottons and cookers

End of survey.

Thank you for providing us with this information. We value your responses and hope you find the program helpful in reducing your risk for HIV and other STDs.

HE/RR-Group-Level Intervention-Session Report Form

Name of Contracting Agency:

Reporting period begin date:	Reporting period end date:

Intervention Name:

GLI Intervention Record

(Please complete one form for each GLI session and submit with corresponding participant sign-in form and individual participant forms.)

Date of Session: _____

Session number in intervention cycle: _____

Duration of event: _____**minutes**

Location where intervention took place (from intervention workplan):

_____

_____

Total number of Clients Attending session: _____

Client primary risk (Indicate the **proportion** of the total number of client contacts whose primary risk was one or more of the following):

_____ MSM

_____ IDU

_____ MSM/IDU

_____ Sex with Transgender

_____ Heterosexual Contact

_____ Other/Risk Not Identified

Proportion by HIV Status: *(enter total number of each)*

_____ HIV status positive

_____ HIV status negative

_____ HIV status unknown

Proportion by gender: *(enter total number of each)*

_____ Male

_____ Female

_____ Transgender

_____ Unknown

Proportion by ethnicity: *(enter total number of each)*

_____ Hispanic or Latino

_____ Not Hispanic or Latino

_____ Unknown

Proportion by Race: *(enter total number of each)*

_____ American Indian or Alaska Native

_____ Asian

_____ Black or African American

_____ Native Hawaiian or Other Pacific Islander

_____ White

Proportion by Age: *(enter total number of each)*

_____ Under 13 years

_____ Age 13-18 years

_____ Age 19-24 years

_____ Age 25-34 years

_____ Age 35-44 years

_____ Age 45 years and older

Activities (identify by number from HE/RR and Outreach Activity list or attach list and circle activities):

If session included 10.01 Practice-Condom/barrier use, what percentage of clients demonstrated proper use of a condom: _____

☐ **Check if a video was used to deliver HIV prevention message**

Number of Materials Distributed:

_____ Male Condoms

_____ Female Condoms

_____ Bleach/safer injection kits

_____ HIV Educational Materials

_____ STD Educational Materials

_____ Hepatitis Education Material

_____ Safer sex kits

_____ Referral lists

_____ Role Model Stories

_____ Other (specify):

Comments:

HIV Prevention Participant Sign-In Form

Using one line per person, please sign-in with the following information in order to maintain confidentiality of identity:			**Meeting Dates** Please initial the column indicating meeting dates attended.							
	1st & 3rd letter of your first **name and** last **name**	**Birthday (month/day/year)**								
1		_____/_____/_____								
2		_____/_____/_____								
3		_____/_____/_____								
4		_____/_____/_____								
5		_____/_____/_____								
6		_____/_____/_____								
7		_____/_____/_____								
8		_____/_____/_____								
9		_____/_____/_____								
10		_____/_____/_____								
11		_____/_____/_____								
12		_____/_____/_____								
13		_____/_____/_____								
14		_____/_____/_____								

Name of Contracting Agency:	Intervention Name:

Thank you for providing this information so that we can evaluate our program. Be assured that your identity will remain anonymous and your participation confidential. Your assistance is appreciated!

HIV Risk Behavior Questionnaire II (completed at last session)	
The following information is needed to identify you as a participant in this program while maintaining your confidentiality.	
1st & 3rd letter of your **first name** _____ _____	1st & 3rd letter of your **last name** _____ _____
Your birth date (month/day/year): ___/___/_____	Your age:

1. **If asked to demonstrate how to use a condom correctly, do you feel confident that you can do this?**

☐ No ☐ Yes

2. **After participating in the HIV prevention program, which of the following is true for you? (check all that apply)**

☐ **I learned my behavior is not putting me at risk for HIV or other STDs**

☐ **I recognize my behaviors that put me at risk for HIV and STDs and I am thinking about making the following changes (check all that apply)**

- ☐ I will reduce the number of sex partners I have sex with during a given period of time
- ☐ I will increase my use of condoms when I have anal or vaginal sex
- ☐ I will use condoms anytime I don't know my partners HIV/STD status
- ☐ I will not share used drug injection equipment
- ☐ I will seek treatment for my addiction
- ☐ I will reduce my use of drugs or alcohol
- ☐ Other (please specify)_____

☐ **I recognize my behaviors that put me at risk and I have taken steps to reduce my risk of HIV and STDs; please identify steps you have taken (please choose all that apply):**

- ☐ I reduced the number of partners I have sex with
- ☐ I am committed to a monogamous relationship (only have one sex partner)
- ☐ I am using condoms more often
- ☐ I talked to my last sex partner about the risks of HIV and STDs
- ☐ I have insisted on condom use with my sex partner(s)
- ☐ I have enrolled in treatment for my addiction
- ☐ I have changed my pattern of drug or alcohol use
- ☐ I refused to share drug injection equipment
- ☐ I have a plan for cleaning or obtaining sterile drug injection equipment
- ☐ Other (please specify)

_____

☐ **I recognize my behaviors that put me at risk for HIV and STDs but do not plan on changing my behavior; please identify why:**

- ☐ I do not think the risk is great enough
- ☐ I have difficulty negotiating for safer sex, for example its difficult to ask my partner(s) to use a condom
- ☐ I am afraid my partner will not have sex with me
- ☐ I am afraid I might loose my partner
- ☐ My addiction is not putting me at risk for HIV and STDs
- ☐ Cleaning my drug injection equipment is too much trouble
- ☐ Other (please specify)

_____

3. **Please help us improve our programs by rating the statements and supplying answers to the questions below. Your answers will allow us to offer feedback to the instructor and will be used for program improvement.**

	Not at all		**Half the time**		**To a great extent**
1. I clearly understood the goals of each HIV/STD prevention session.	1	2	3	4	5
2. The prevention educator appeared to know the information well.	1	2	3	4	5
3. The information was delivered in a way that was understandable.	1	2	3	4	5
4. There was plenty of time to have questions answered.	1	2	3	4	5
5. The facilitator was respectful of participant's experiences, ideas, and contributions.	1	2	3	4	5

Is there anything you would suggest to make this program better or that you think would help people change their risk behavior for HIV, STDs, or hepatitis?

What did you like **best** about this program or what did you think was most important?

What did you like **least** about this program? Why did you not like this part?

Thank you for providing us with this information!
We value your responses and we hope this program has given you tools to make healthy life choices.

Permission to Contact Form

We hope that you found the information and skills learned in this HIV program to be helpful in reducing your risk for HIV and other sexually transmitted diseases.

Today you were asked to complete a questionnaire about HIV risk behaviors. We would like to follow-up with you in the near future to ask similar questions related to your behavior. This is completely voluntary, but would be very helpful in providing information to support providing future HIV risk reduction programs like the one you just attended.

In order to send the follow-up questionnaire, we need your permission to contact you and a contact address. Please understand that your contact information will not be shared with anyone outside of this agency and your identity will be kept confidential.

A self addressed stamped envelope will be sent with the questionnaire so that you may return the questionnaire at no cost to you.

Name: _____

Contact Address: _____

_____

By signing below I give _____ permission to mail me an HIV Risk Behavior Follow-Up questionnaire at the address I have listed above. I understand that by signing this form, I am only giving permission to use my contact information to send the questionnaire and the information will not be used for any other purpose. I also understand that my name and address will be kept confidential by the agency from which it was received. This permission to contact form expires 6 months from the date signed below.

_____

Your Signature Date

HIV Risk Behavior Questionnaire III

(completed 30-60 days after attending prevention program)

The following information is needed to identify you as a participant in this program while maintaining your confidentiality.

1st & 3rd letter of your **first name** _____ _____	1st & 3rd letter of your **last name** _____ _____
Your birth date (month/day/year): ___/___/_____	Your age:

Date Completed: _____/_____/_____

We need your help! Recently, you participated in an HIV prevention program. We are following up with you to gather information about your HIV risk behaviors. Again, we realize these questions are very personal, but your open and honest answers are very important in helping us develop and fund HIV prevention programs to help Idahoans.

*Please be assured that your answers are **confidential** and the people who use this information **will not know your identity**. There are no right or wrong answers.*

*After completing the following information, **please return in the self-addressed stamped envelope provided**.*

1. **Which best describes the number of different partners you have had sex with in the last month?**

- ☐ 10 or more partners
- ☐ 7-9 partners
- ☐ 4-6 partners
- ☐ 2-3 partners
- ☐ 1 partner
- ☐ abstinent (no anal or vaginal intercourse)

2. **The last time you had sex (anal or vaginal intercourse); did you or your partner use a condom?**

- ☐ No
- ☐ Yes
- ☐ Never had sex

3. **Thinking back over the last month, which best describes your use of condoms for vaginal intercourse?**

- ☐ Did not have vaginal intercourse
- ☐ Never used condoms
- ☐ Used condoms at least 25% of the time
- ☐ Used condoms at least 50% of the time
- ☐ Used condoms at least 75% of the time
- ☐ Used condoms 100% of the time

4. **Thinking back over the last month, which best describes your use of condoms for anal intercourse?**

- ☐ Did not have anal intercourse
- ☐ Never used condoms
- ☐ Used condoms at least 25% of the time
- ☐ Used condoms at least 50% of the time
- ☐ Used condoms at least 75% of the time
- ☐ Used condoms 100% of the time

5a. **Have you used drug injection equipment in the last 30 days?**

☐ No (skip 5b)

☐ Yes - If yes, how many times did you use?
☐ 1 time ☐ 2-5 times ☐ 6-9 times
☐ 10-19 times ☐ 20-29 ☐ 30 and over
(please answer 5b)

5b. **If yes, which of the following best describes the last time you used?**

☐ shared or reused unclean syringe and injection equipment
☐ used new, sterile drug injection equipment
☐ shared disinfected syringe (cleaned with bleach) and used new cottons and cookers

6. **After participating in the HIV prevention program, which of the following is true for you now? (check all that apply)**

☐ My behavior was not putting me at risk for HIV or other STDs before or after the program
☐ I know I have behaviors that put me at risk for HIV and STDs but I have not changed my behavior
☐ I know I have behaviors that put me at risk for HIV and STDs and I am thinking about making changes
☐ I recognized my behaviors that put me at risk and I have taken steps to reduce my risk for HIV and STDs
☐ Other _____

7. **If you have taken steps to change your behavior, how influential was this program in your decision to make changes to reduce your risk?**

☐ not at all influential (I **would** have made changes anyway)
☐ moderately influential (I was thinking about making changes before this program)
☐ very influential (I **would not** have made the changes without this program)

Is there anything more you would like to tell us about the prevention program you attended?

Thank you for taking the time to complete and return this survey.
Your responses will help us in providing future programming.

Attachment H – Reporting Form Outreach

Aggregate Outreach Intervention Report Form

Please complete one form for each outreach event.

Name of Contracting Agency:

Reporting period begin date:	Reporting period end date:

Program Model Name:

Intervention Name:

Outreach Intervention Record

Date of Event: ____/____/____

Duration of event: _____ minutes

Location where intervention took place (from intervention workplan):

Proportion (number) by gender:

____ Male
____ Female
____ Transgender
____ Unknown

Outreach Activities (identify by number from Outreach Activity list or attach list and circle activities):

Total number of client contacts =

Proportion (number) by ethnicity:

____ Hispanic or Latino
____ Not Hispanic or Latino
____ Unknown

Client primary risk (Indicate the **proportion/number** of the total number of client contacts whose primary risk was one or more of the following):

_____ MSM
_____ IDU
_____ MSM/IDU
_____ Sex with Transgender
_____ Heterosexual Contact
_____ Other/Risk Not Identified

Proportion (number) by Race:

____ American Indian or Alaska Native
____ Asian
____ Black or African American
____ Native Hawaiian or Other Pacific Islander
____ White
____ Unknown

Proportion (number) by Age:

____ Under 13 years
____ Age 13-18 years
____ Age 19-24 years
____ Age 25-34 years
____ Age 35-44 years
____ Age 45 years and older

Number of Materials Distributed:

____ Male Condoms
____ Female Condoms
____ Bleach/safer injection kits
____ HIV Education Materials
____ STD Education Materials
____ Hepatitis Education Materials
____ Safer sex kits
____ Referral lists
____ Role Model Stories
____ Other (specify):

Comments:

Attachment I – Reporting Forms Health Communication/Public Information

Health Communications / Public Information Intervention Report Form

Name of Contracting Agency:	
Intervention Name:	
Reporting period begin date:	Reporting period end date:

During this period, we completed the following health communications / public information activities (check each that is applicable for this **specific intervention** and enter the number of items and exposure):

Delivery Method	**Outputs** *complete for each delivery method reported*	**Activities** *identify by code number from HC/PI activity list*
☐ In person	Total Number of presentations from attached HC/PI log sheet:	
☐ Internet	Number of email messages sent: Key message: Number of web hits:	
☐ Printed materials-magazines/newspapers	Number of ads/articles produced: Number of times printed: Estimated number of persons exposed to material:	
☐ Printed materials-pamphlets/brochures	Number of pamphlets produced: and/or Number of pamphlets distributed: and/or Number of direct mailings:	
☐ Printed materials-posters/billboards Start date: End date:	Key message: Estimated number of persons exposed to message:	
☐ Telephone	Number of hotline callers: And/or Number of callers referred:	
☐ Radio ☐ Television Start date: End date:	Key message: Number of times aired: Estimated number of persons exposed to message:	
☐ Video	Number of times shown:	
☐Other	Specify:	

Health Communication /Public Information Log Form

presentations, lectures, health fairs

Please attach to HCPI Report Form

Name of Contracting Agency:

Intervention Name:

Start and End Date	Location	Event and Key Message	Materials Distribution Indicate **number** distributed	Estimated Number in Audience
			____ Male condoms ___SSKs ____ Female condoms ____SIKs ____ lubricants ____Referral lists ____ printed material ____ ___________	
			____ Male condoms ___SSKs ____ Female condoms ____SIKs ____ lubricants ____Referral lists ____ printed material ____ ___________	
			____ Male condoms ___SSKs ____ Female condoms ____SIKs ____ lubricants ____Referral lists ____ printed material ____ ___________	
			____ Male condoms ___SSKs ____ Female condoms ____SIKs ____ lubricants ____Referral lists ____ printed material ____ ___________	
			____ Male condoms ___SSKs ____ Female condoms ____SIKs ____ lubricants ____Referral lists ____ printed material ____ ___________	
			____ Male condoms ___SSKs ____ Female condoms ____SIKs ____ lubricants ____Referral lists ____ printed material ____ ___________	

Attachment J – Report Form CLI

Other Community-Level Intervention (CLI) Report Form

Name of Contracting Agency:	State contract: Yes No
Reporting period begin date:	Reporting period end date:
Intervention Name:	

Other Intervention Type

____ Community Mobilization incl. RPC

____ Social Marketing Campaign

____ Community-Wide Event

____ Policy Intervention

____ Structural Intervention

____ Other Type: _____

Describe intervention activity.

Describe outputs and outcome of intervention. Please attach relevant documentation of outputs and outcomes, i.e., RPC minutes, attendance records, policy changes, needs assessment summary, print materials distributed, condoms distributed, etc.

Attachment K – Quarterly Report Template

HIV Prevention Interventions
FY 2006 Quarterly Progress Report

District : _____ Dates: _____ to _____
Submitted by:

Describe activities conducted in the following:

Accomplishments for Interventions

Barriers to implementing interventions

Evaluation activities for interventions

Technical Assistance request:

Schedule of Next Quarter's Contract Activities:

Date/Time	Activity/Event	Location

***Remember**: Attach a copy of media materials (brochures, newsletters, web sites, billboards, etc.) developed or purchased with State STD/AIDS contract funds*

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